Advanced Practice Provider Fellowship Accreditation

American Nurses Credentialing Center

nursingworld.org/organizational-programs/accreditation/appfa

8403 Colesville Road, Suite 500
Silver Spring, MD 20910
1.800.284.2378

ADVANCED PRACTICE PROVIDER FELLOWSHIP ACCREDITATION®

APPLICATION FORM

Complete all sections and submit via email to appfa@ana.org.

NOTE: Your program will receive an invoice upon approval of this application. The application fee must be paid in full prior to the accreditation decision.

SECTION I: DEMOGRAPHICS

PROGRAM NAME

Include the name of the fellowship program. If accredited, this name will be used on the program's certificate, award, and in the APPFA directory.

ORGANIZATION NAME

Specify name of the organization/health system where learners practice.

TYPE OF APPLICATION

☐ Initial Accreditation ☐ Re-accreditation

If re-accrediting, enter the program's PTAP number:

Note: Programs transitioning from PTAP to APPFA will be considered **new applicants** under APPFA.

PROGRAM MAILING ADDRESS

STREET

CITY STATE ZIP

COUNTY

COUNTRY

SECTION I: DEMOGRAPHICS (CONTINUED)

WEBSITE

If accredited, would you like ANCC to display your website link in the *APPFA Directory*?

☐ Yes ☐ No

If yes, list URL here:

CNO/CMO AND CREDENTIALS

NAME

CREDENTIALS

EMAIL

PHONE

SECTION II: ELIGIBILITY VERIFICATION

PROGRAM DIRECTOR

The APP Fellowship Program Director holds a current valid license as a PA/APRN, a national certification as a PA or APRN, and has education or experience in adult learning.

☐ Yes ☐ No

NAME

CREDENTIALS

EMAIL

PHONE

PA or APRN LICENSE NUMBER

STATE OF ISSUE

HIGHEST DEGREE

DATE CONFERRED

NAME OF UNIVERSITY

LOCATION (CITY/STATE)

YEAR OF GRADUATION

See the *APPFA Application Manual* for eligibity requirements. The APPFA Team may ask for verification of education or experience in adult learning principles.

PROGRAM CO-DIRECTOR (If applicable)

The APP Fellowship Program Director holds a current valid license as a PA/APRN, a national certification as a PA or APRN, and has education or experience in adult learning.

☐ Yes ☐ No

NAME AS IT APPEARS ON PA/APRN LICENSE

CREDENTIALS

EMAIL

PHONE

LICENSE NUMBER

STATE OF ISSUE

HIGHEST DEGREE

DATE CONFERRED

NAME OF UNIVERSITY

LOCATION (CITY/STATE)

YEAR OF GRADUATION

See the APPFA application manual for eligibility requirements. The APPFA Team may ask for verification of education or experience in adult learning principles.

PROGRAM ELIGIBILITY

The Program Director(s) has the accountability and oversight of all participating sites/service lines, and specialty(ies), educational design process, and agrees to serve as the primary point of contact with the APPFA office.

At least one cohort has graduated from the fellowship program: ☐ Yes ☐ No

YEAR/MONTH PROGRAM STARTED

PROGRAM LENGTH (MONTHS)

YEAR/MONTH FIRST COHORT GRADUATED

The applicant:

Has evidence that learners will be paid at least the applicable minimum wage (according to Federal, State, and local requirements) and are not required to pay to participate in the program.

☐ Yes ☐ No

Abides by the Equal Employment Opportunity (EEO) policy to ensure freedom from discrimination on the basis of protected classes such as race, color, sex, national origin, religion, age, disability or genetic information.

☐ Yes ☐ No

Is in compliance with all applicable local, state, federal, and international laws and regulations that affect the applicant's ability to meet the Advanced Practice criteria.

☐ Yes ☐ No

Was the program accreditation ever denied, suspended, or revoked by ANCC or any other organization?

☐ Yes ☐ No If yes, describe:

NUMBER OF LEARNERS FOR SURVEY

How many learners have participated in the program during the 12 months preceding the application form submission (include current participants and graduates, regardless of their current status in the organization).

N =

This will be your program's survey N. At least 51% of this N must respond to the survey for the program to move forward in the accreditation process. The N only includes learners from eligible sites and specialty(ies)/service line(s).

PARTICIPATING SITES

List the eligible sites that participate in the Program and corresponding Site Coordinators (SCs), if applicable. Utilize the *Application Addendum Form* if the program has more than 5 eligible participating sites. See the *APPFA Application Manual* for definitions and eligibility details, in summary site requirements include:

- A **minimum of one** learner must have **completed** the program in full at the site to be eligible for accreditation:
  - — New applicants must have a minimum of one learner complete the program at each site within the 24-months (2-year period) prior to the application form submission;
  - — Reaccrediting programs must have a minimum of one learner complete the program at each site within the 48-months (4-year period) prior to the application form submission.

1

SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SC NAME (AS IT APPEARS ON PA/APRN LICENSE) AND CREDENTIALS

LICENSE NUMBER | STATE OF ISSUE

2

SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SC NAME (AS IT APPEARS ON PA/APRN LICENSE) AND CREDENTIALS

LICENSE NUMBER | STATE OF ISSUE

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

3

SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SC NAME (AS IT APPEARS ON PA/APRN LICENSE) AND CREDENTIALS

LICENSE NUMBER | STATE OF ISSUE

4

SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SC NAME (AS IT APPEARS ON PA/APRN LICENSE) AND CREDENTIALS

LICENSE NUMBER | STATE OF ISSUE

5

SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SC NAME (AS IT APPEARS ON PA/APRN LICENSE) AND CREDENTIALS

LICENSE NUMBER | STATE OF ISSUE

NON-PARTICIPATING SITES

List the sites that **DO NOT** participate in the Program. *Attach the Application Addendum Form if program has more than 5 non-participating sites.*

1. SITE NAME
2. SITE NAME
3. SITE NAME
4. SITE NAME
5. SITE NAME

ATTACH ORGANIZATIONAL CHARTS

☐ Check box to confirm email attachment.

The organizational chart(s) should:

- Demonstrate the relationship of key leaders within the organization
- Include all participating organizations for a multi-site program
- Clearly identify the fellowship program leadership
- Represent fellowship structure and key stakeholders
  - — Names, roles, and credentials should be included on charts for key program stakeholders.

FOR SINGLE-SITE PROGRAMS ONLY

Skip to page 8 if multi-site program.

Number of Learners in Application Review Timeframe*

1. Denote which specialty or service line(s) are eligible for accreditation review by placing the year the program started for each specialty/service line in the first column of the table on page 7:
   a. Refer to specialty or service line(s) definitions in the *APPFA Application Manual* to ensure proper classification of specialties or services lines into approved categories.

> **ELIGIBILITY REMINDER:** A ***minimum of one*** learner must have completed the program ***at the site*** to be eligible for accreditation. Additionally, a ***minimum of one*** learner must have completed the program ***within the specialty or service line*** to be eligible for accreditation.

2. Indicate how many learners have participated in each specialty or service line(s) during the application review timeframe by placing a number in the second column of the table on page 7:
   a. *New programs must indicate the number of learners in each specialty or service line during the 24-months (2-year period) prior to the application form submission.
   b. *Reaccrediting programs must indicate the number of learners in each specialty or service line during the 48-months (4-year period) prior to the application form submission.
   c. A minimum of one learner must have completed the program in each specialty or service line included on this application within the 24-month or 48-month time frame prior to application submission.

Only add numbers under eligible specialty(ies)/service line(s).
If ineligible, please keep the box blank. Do not put "N/A" or "0".

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

SPECIALTY OR SERVICE LINE	YEAR PROGRAM STARTED IN SPECIALTY/ SERVICE LINE	NUMBER OF LEARNERS IN APPLICATION REVIEW TIMEFRAME
Medical		
Surgical		
Medical-Surgical		
Oncology		
Step Down		
Critical Care		
Labor & Delivery		
Ante/Postpartum		
Labor, Delivery, Recovery and Postpartum (LDRP)		
Neonatal Intensive Care Unit (NICU)		
Pediatrics		
Pediatric Intensive Care Unit (PICU)		
Operating Room		
Post Anesthesia Recovery Unit (PACU)		
Same Day/Ambulatory Procedure		
Psychiatric		
Rehabilitation		
Ambulatory		
Emergency Department		
Specialty Practice		
Acuity Adaptable (Universal Bed)		
Long Term Care		
Preoperative		
Home Care		
Hospice		
Centralized Function		
APP Specialty Provide name(s) of Specialty(ies)		
Primary Care		
Other — Contact APPFA Team.		
Total # of Learners per Specialty or Service Line(s) in Review Timeframe		0

FOR MULTI-SITE PROGRAMS ONLY Skip to page 10 if single-site program.

PROGRAM CONSISTENCY

Provide an executive summary describing how the program is consistently operationalized across all sites (500 words or less).

NUMBER OF LEARNERS IN APPLICATION REVIEW TIMEFRAME*

1. List each site included on application pages 4 and 5 under the "site name" row in accordance with organization names used provided prior.
2. Denote which specialty or service line(s) are eligible for accreditation review by placing the year the program started for each specialty/service line in the corresponding column of the table on pages 8 and 9:
   a. Refer to specialty or service line definitions in the *AFFPA Application Manual* to ensure proper classification of specialty or service line(s) into approved categories.

ELIGIBILITY REMINDER: A ***minimum of one*** learner must have completed the program ***at the site*** to be eligible for accreditation. Additionally, a ***minimum of one*** learner must have completed the program ***within the specialty or service line*** to be eligible for accreditation.

3. Indicate how many learners have participated in each specialty or service line(s) during the application review timeframe by placing a number in the corresponding column of the table on page 9:
   a. *New programs must indicate the number of learners in each specialty or service line during the 24-months (2-year period) prior to the application form submission;
   b. *Reaccrediting programs must indicate the number of learners in each specialty or service line during the 48-months (4-year period) prior to the application form submission).
   c. A minimum of one learner must have completed the program in each specialty or service line included on this application within the 24-month or 48-month time frame prior to application submission.

Attach the Application Addendum Form if program has more than 5 sites.

Only add numbers under eligible specialty(ies)/service line(s).
If ineligible, please keep the box blank. Do not put "N/A" or "0".

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

SITE NAME	1.		2.		3.		4.		5.	
SPECIALTY OR SERVICE LINE	Year Program Started at Specialty/ Service Line	Number of Learners in Application Review Timeframe	Year Program Started at Specialty/ Service Line	Number of Learners in Application Review Timeframe	Year Program Started at Specialty/ Service Line	Number of Learners in Application Review Timeframe	Year Program Started at Specialty/ Service Line	Number of Learners in Application Review Timeframe	Year Program Started at Specialty/ Service Line	Number of Learners in Application Review Timeframe
Medical										
Surgical										
Medical-Surgical										
Oncology										
Step Down										
Critical Care										
Labor & Delivery										
Ante/Postpartum										
Labor, Delivery, Recovery and Postpartum (LDRP)										
Neonatal Intensive Care Unit (NICU)										
Pediatrics										
Pediatric Intensive Care Unit (PICU)										
Operating Room										
Post Anesthesia Recovery Unit (PACU)										
Same Day/Ambulatory Procedure										
Psychiatric										
Rehabilitation										
Ambulatory										
Emergency Department										
Specialty Practice										
Acuity Adaptable (Universal Bed)										
Long Term Care										
Preoperative										
Home Care										
Hospice										
Centralized Function										
APP Specialty Provide name(s) of Specialty										
Primary Care										
Other — Contact APPFA Team.										
Total # of Learners per Specialty or Service Line(s) in Review Timeframe	0		0		0		0		0	

ANCC DESIGNATION STATUS

Provide the following information for your healthcare organization or program.

- ☐ Magnet® Recognized
- ☐ Pathway to Excellence® Designation
- ☐ PTAP Accredited
- ☐ Joint Accreditation
  (Joint Accreditation differs from Joint Commission)
- ☐ ANCC Accredited Provider Unit (Provider unit differs from approver unit; only provider status will be confirmed.)

ORGANIZATION DESCRIPTION

Brief description of the **healthcare organization** and/or **health system** (if applicable) (500 words or less).

BRIEF HISTORY AND DESCRIPTION OF THE **APP FELLOWSHIP** SEEKING ACCREDITATION

(500 words or less)

VENDOR PRODUCTS USED

NAME OF VENDOR PRODUCT(S)

Check if none.

ELIGIBILITY CRITERIA FOR APP FELLOWSHIP APPLICANTS

Must include:

1. Graduation from an accredited PA or APRN program
2. Current, unencumbered licensure (or international equivalent) as a PA or APRN
3. National certification as a PA or APRN, and other program requirements.

SECTION IV: ATTESTATION

Insert your name, title, and organization name below electronically. Forms received without the required information will incur a delay in processing which will cause a delay in the review of the accreditation application.

IMPORTANT: Please **do not lock** the application form when applying your electronic signature. ANCC requires submission of an unlocked document and will return all locked applications for resubmission.

I _____[Name], _____[Title] of _____[Organization] (hereinafter referred to as Applicant Organization), attest, by my signature below, that I am duly authorized to submit this application on behalf of the Applicant Organization for program accreditation offered by the American Nurses Credentialing Center (ANCC) and to make the statements herein.

On behalf of Applicant Organization, I acknowledge and agree to the following:

- I have reviewed and understand the Advanced Practice Provider Fellowship Accreditation® (APPFA) eligibility requirements and criteria as described in the current Advanced Practice Provider Fellowship Accreditation® (APPFA) Application Manual and any addendums to the manual posted on the Advanced Practice Provider Fellowship Accreditation® website (collectively, APPFA Manual), incorporated herein by reference.
- I understand and agree that Applicant Organization will comply with all eligibility requirements and accreditation criteria throughout the application phase, the review phase, and accreditation period, and that Applicant Organization will notify ANCC promptly if, for any reason while this application is pending or during any accreditation period, Applicant Organization does not maintain compliance.
- I have reviewed and understand the APPFA application and appraisal review process as described in the APPFA Manual, incorporated herein by reference, which controls the review, decision making and accreditation process for APPFA.
- I have reviewed, understand, and agree to the APPFA investment fee structure and terms outlined in detail at https://www.nursingworld.org/organizational-programs/accreditation/appfa/appfa-accreditation-fees/ and in the APPFA Manual, incorporated herein by reference.
- I understand and agree that all fees and outstanding balances owed to APPFA must be paid in full prior to receipt of an accreditation decision as described in the APPFA Manual and incorporated herein by reference.
- I understand and agree that failure to pay fees when due or failure to make arrangements to pay fees will result in action against an applicant or APPFA accredited organization's credential, up to and including denial of an application, suspension, or revocation of accreditation, as described in the APPFA Manual and incorporated herein by reference.
- I understand and agree that all fees are deemed earned on the date payment is due.
- I understand and agree that any disputes regarding invoices should be raised with ANCC prior to payment. Payment of the invoice shall be proof of acceptance of the classification of the Applicant Organization for billing purposes and acceptance of the fees therein.
- I understand and agree that submission of an application or completion of the processes outlined in the APPFA Manual does not, in and of itself, guarantee APPFA accreditation.

SECTION IV: ATTESTATION

Insert your name, title, and date below electronically. Forms received without an electronic signature incur a delay in processing which will cause a delay in the review of the accreditation application.

IMPORTANT: Please **do not lock** the application form when applying your electronic signature. ANCC requires submission of an unlocked document and will return all locked applications for resubmission.

- I understand and agree, if accredited, the name of Applicant Organization Fellowship Program will be included in the official listing of ANCC accredited programs with permission.
- I authorize ANCC staff and the Commission on Accreditation of Practice Transition Programs (COA-PTP) to make whatever inquiries and investigations that they, in their sole discretion, deem necessary to obtain or verify information submitted with or necessary for review of this application, subject to applicable policies, laws, or regulations.
- I expressly acknowledge and agree that information accumulated by ANCC through the accreditation process may be used for statistical, research, and evaluation purposes and that ANCC may enter into agreements to release anonymous and aggregate data to third parties. Otherwise, subject to the mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without Applicant Organization's permission.
- I understand and agree that the written documentation will be the original, unique work of the Applicant Organization. Further, I understand and agree that written documentation will be substantially the work of human authorship and expressly acknowledge that the written documentation will not violate the intellectual property rights of ANCC and third parties. I understand and agree that any use of artificial intelligence programs, including but not limited to generative AI programs like Co-Pilot, ChapGPT, and Grammarly, will be limited to uses like proofreading or to providing minimal drafting assistance.
- I understand that providing false, misleading, or incomplete information is grounds for denial of the application, suspension, or revocation at any point during the review process or whenever this information is discovered.
- I have reviewed and understand the appeals process described in the APPFA Manual and incorporated herein by reference, that allows applicants for APPFA accreditation or reaccreditation the opportunity to appeal an adverse decision rendered as a result of a decision made by the COA-PTP.
- I understand and agree that any dispute arising in connection with the Applicant Organization's application or this attestation will be governed by Maryland law.

I certify that the information provided on and with this application is true, complete, and accurate.

_____
Name

_____
Title

_____
Date

Complete all sections and submit via email to **appfa@ana.org**.