

PRACTICE TRANSITION ACCREDITATION PROGRAM®

APPLICATION FORM

Complete all sections and submit via email
to practicetransition@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 organization/
practice setting/system where the program is
operationalized. If accredited, this name will be
used on the program's certificate, plaque, and
in the ANCC directory if accredited.

ORGANIZATION NAME

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

TYPE OF PROGRAM

RN Residency

RN Fellowship

TYPE OF APPLICATION

Initial Accreditation

Re-Accreditation

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

PROGRAM MAILING ADDRESS

STREET

CITY

STATE

ZIP

COUNTY

COUNTRY

TIME ZONE

SECTION I: DEMOGRAPHICS (CONTINUED)

WEBSITE

If accredited, would you like your website link in the ANCC directory of accredited practice transition program?

Yes No

If yes, list URL here:

CNO/CMO AND CREDENTIALS (System CNO for multi-site programs)

<input type="text"/>	<input type="text"/>
NAME	CREDENTIALS
<input type="text"/>	<input type="text"/>
EMAIL	PHONE

SECTION II: ELIGIBILITY VERIFICATION: PROGRAM DIRECTOR, RESIDENTS/FELLOWS, PARTICIPATING SITES AND PRACTICE SETTINGS

PROGRAM DIRECTOR

The RN Residency/RN Fellowship Program Director holds a current valid license as an RN, a graduate degree or higher (either the baccalaureate or graduate degree must be in nursing or international equivalent), and has education or experience in adult learning.

Yes No

<input type="text"/>	<input type="text"/>	
NAME	CREDENTIALS	
<input type="text"/>	<input type="text"/>	
EMAIL	PHONE	
<input type="text"/>	<input type="text"/>	
LICENSE NUMBER	STATE OF ISSUE	
<input type="text"/>	<input type="text"/>	<input type="text"/>
MASTER'S DEGREE (CREDENTIALS CONFERRED)	DATE CONFERRED	YEAR OF GRADUATION
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF UNIVERSITY	LOCATION (CITY/STATE)	
<input type="text"/>	<input type="text"/>	<input type="text"/>
BACCALAUREATE DEGREE (CREDENTIALS CONFERRED)	DATE CONFERRED	YEAR OF GRADUATION
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF UNIVERSITY	LOCATION (CITY/STATE)	

See the *2024 PTAP Application Manual* for eligibility requirements. The PTAP/APPFA Team may ask for verification of education or experience in adult learning principles.

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

PROGRAM ELIGIBILITY

The Program Director has the accountability and oversight of all participating sites and practice settings, educational design process, and agrees to serve as the primary point of contact with the PTAP/APPFA office.

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

<input type="text"/>	<input type="text"/>	<input type="text"/>
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 or international equivalents) 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 ANCC PTAP 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 practice setting(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. Each site within a program must be from the same healthcare system. The maximum size of an accreditable program is up to **30 sites**. See the *2024 PTAP 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.

SITE COORDINATOR

- In a *multisite, multi-practice setting* program **11 sites or larger**, each site **must** have a Site Coordinator (SC). The SC must have a direct or dotted line of authority to the Program Director. The PD **may not** be a SC.
- In a *multisite, multi-practice setting* program of **2-10 sites**, each site **may** have a Site Coordinator (SC). The SC must have a direct or dotted line of authority to the Program Director. The PD **may** be a SC.
- In a *multisite, single practice setting* program, each site **may** utilize Site Coordinators (SC) to ensure program consistency. The PD **may** be a SC.
- SCs must maintain a current, valid license as an RN, hold a baccalaureate degree or higher in nursing, and have education and/or experience in adult learning principles.

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

PARTICIPATING SITES

(MULTISITE, MULTI-PRACTICE SETTING PROGRAMS 11 SITES OR LARGER, EACH SITE MUST HAVE A SITE COORDINATOR)

1

[Text input field for Site Name]

SITE NAME

[Text input field for Street]

STREET

[Text input field for City]

CITY

[Text input field for State]

STATE

[Text input field for ZIP]

ZIP

[Text input field for Geographic Location]

GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

[Text input field for Site Coordinator Name and Credentials]

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES.

Yes

No

[Text input field for License Number]

LICENSE NUMBER

[Text input field for State of Issue]

STATE OF ISSUE

[Text input field for Highest Degree]

HIGHEST DEGREE (CREDENTIALS CONFERRED)

[Text input field for Date Conferred]

DATE CONFERRED

2

[Text input field for Site Name]

SITE NAME

[Text input field for Street]

STREET

[Text input field for City]

CITY

[Text input field for State]

STATE

[Text input field for ZIP]

ZIP

[Text input field for Geographic Location]

GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

[Text input field for Site Coordinator Name and Credentials]

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES.

Yes

No

[Text input field for License Number]

LICENSE NUMBER

[Text input field for State of Issue]

STATE OF ISSUE

[Text input field for Highest Degree]

HIGHEST DEGREE (CREDENTIALS CONFERRED)

[Text input field for Date Conferred]

DATE CONFERRED

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

3

[Redacted]

SITE NAME

[Redacted]

STREET

[Redacted]

CITY

STATE

ZIP

GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

[Redacted]

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES.

Yes

No

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

[Redacted]

LICENSE NUMBER

STATE OF ISSUE

[Redacted]

HIGHEST DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

4

[Redacted]

SITE NAME

[Redacted]

STREET

[Redacted]

CITY

STATE

ZIP

GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

[Redacted]

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES.

Yes

No

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

[Redacted]

LICENSE NUMBER

STATE OF ISSUE

[Redacted]

HIGHEST DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

5

SITE NAME

STREET

CITY

STATE

ZIP

GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES.

 Yes No

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

LICENSE NUMBER

STATE OF ISSUE

HIGHEST DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

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

ORGANIZATIONAL CHARTS

Check box to confirm email attachment of Organizational Chart for your Organization/Healthcare System.

1 Organization/Healthcare System Chart

- Demonstrate the relationship of key leaders within the organization
 - Include all participating sites for a multi-site program
 - CNO/CMO (System-level for multi-site programs)
 - Key program stakeholders
- Names, roles, and credentials should be included on charts for key program stakeholders.

Check box to confirm email attachment of Organizational Chart for RN Residency/Fellowship.

2 RN Residency/Fellowship Organizational Chart

- Clearly identify the RN residency/fellowship program leadership
- Represent RN residency/fellowship structure and key stakeholders
 - Names, roles, and credentials should be included on charts for key program stakeholders.
- For *multisite, multi-practice setting* programs with **11 sites or larger**, each site **must** have a Site Coordinator (SC) with a direct or dotted line of authority to the Program Director. The PD **may not** be a SC.
- For *multisite, multi-practice setting* programs with **2-10 sites**, each site **may** have a SC. The SC must have a direct or dotted line of authority to the PD. The PD **may** be a SC.
- In a *multisite, multi-practice setting* program, each eligible practice setting **must** have a Practice Setting Coordinator (PSC). The PSC must have a dotted or direct line of authority to the PD.

FOR SINGLE-SITE PROGRAMS ONLY

Skip to [page 9](#) if multi-site program.

Number of Learners in Application Review Timeframe*

1. Indicate the name of the Practice Setting Coordinator (PSC), if applicable, in the first column. In a single site, multi-practice setting program, Practice Setting Coordinators (PSC) **may** be utilized to ensure program consistency.
2. Denote which practice setting(s) are eligible for accreditation review by indicating the year the program started in the second column of the table on [page 8](#):
 - a. Refer to practice setting(s) definitions in the *2024 PTAP Application Manual*, Appendix A, to ensure proper classification of practice setting(s) into approved categories.
3. Indicate how many learners have participated in each practice setting(s) during the application review timeframe by placing a number in the third column of the table on page 8:
 - a. *New programs must indicate the number of learners in each practice setting during the 24-months (2-year period) prior to the application form submission.
 - b. *Reaccrediting programs must indicate the number of learners in each practice setting during the 48 months (4-year period) prior to the application form submission.
 - c. A minimum of one learner must have completed the program at each practice setting included on this application within the 24-month or 48-month time frame prior to application submission.

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 practice setting** to be eligible for accreditation.

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

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

PRACTICE SETTING (PS)	PRACTICE SETTING COORDINATOR <small>Optional for single site, multi-practice setting programs</small>	YEAR PROGRAM STARTED AT PRACTICE SETTING	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			
Other — Contact PTAP/AFFPA Team.			
Total # of Learners per Practice Setting(s) in Review Timeframe			

FOR MULTI-SITE PROGRAMS

Skip to [page 12](#) 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, 5, and 6 under the “site name” row in accordance with organization names provided prior.
2. Indicate the name of the Practice Setting Coordinator (PSC), if applicable. In a multisite, multi-practice setting program, each eligible practice setting **must** have a centralized person, called the Practice Setting Coordinator (PSC), coordinating the practice setting curriculums across all sites within the program.
3. Denote which practice setting(s) are eligible for accreditation review by indicating the year the program started in the second column of the table on [pages 10](#) and [11](#):
 - a. Refer to practice setting(s) definitions in the *2024 PTAP Application Manual*, Appendix A, to ensure proper classification of practice setting(s) into approved categories.
4. Indicate how many learners have participated in each practice setting(s) during the application review timeframe by placing a number in the second column of the table on [pages 10](#) and [11](#).
 - a. ***New programs** must indicate the number of learners in each practice setting during the **24-months (2-year period)** prior to the application form submission.
 - b. ***Reaccrediting programs** must indicate the number of learners in each practice setting during the **48 months (4-year period)** prior to the application form submission.
 - c. A minimum of one learner must have completed the program at each practice setting included on this application within the 24-month or 48-month time frame prior to application submission.

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 practice setting** to be eligible for accreditation.

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

Only add numbers under eligible practice settings.
If ineligible, please keep the box blank. Do not put "N/A" or "0".

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

MULTISITE, MULTI-PRACTICE SETTING PROGRAMS MUST HAVE AN IDENTIFIED PRACTICE SETTING COORDINATOR AT EACH PRACTICE SETTING

SITE NAME	PRACTICE SETTING COORDINATOR <small>Required for multisite, multi-practice setting programs</small>	1.		2.		3.		4.		5.	
		Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	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											

PRACTICE SETTINGS (PS)	PRACTICE SETTING COORDINATOR	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe
Preoperative											
Home Care											
Hospice											
Centralized Function											
Other — Contact PTAP/AFFPA Team.											
Total # of Learners per Practice Setting(s) in Review Timeframe											

ANCC DESIGNATION STATUS

Provide the following information for your healthcare organization or program.

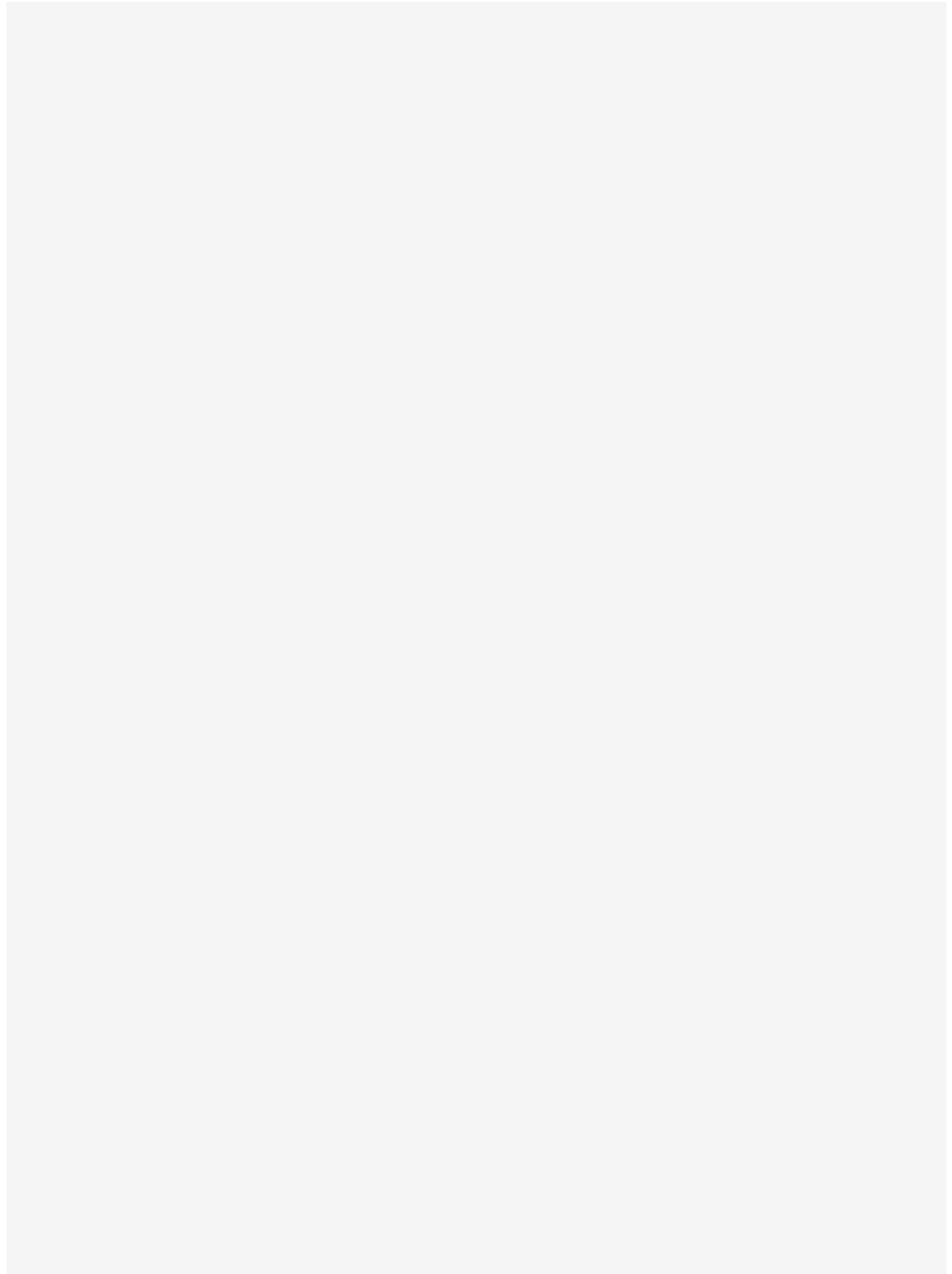
- Magnet® Recognized
 - Pathway to Excellence® Designation
 - APPFA™ Accredited
 - Joint Accreditation™
 - ANCC Accredited Provider Unit (Provider unit differs from approver unit; only provider status will be confirmed.)
-

ORGANIZATION DESCRIPTION

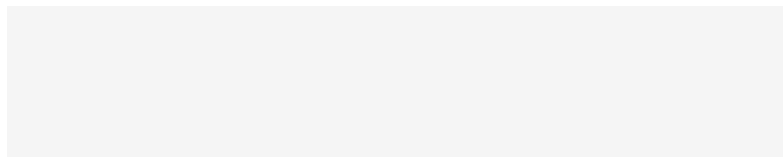
Brief description of the **healthcare organization** and/or **health system** (if applicable) (500 words or less).

**BRIEF HISTORY AND
DESCRIPTION OF THE
RN RESIDENCY/
RN FELLOWSHIP
SEEKING
ACCREDITATION**

(500 words or less)



**VENDOR
PRODUCTS USED**

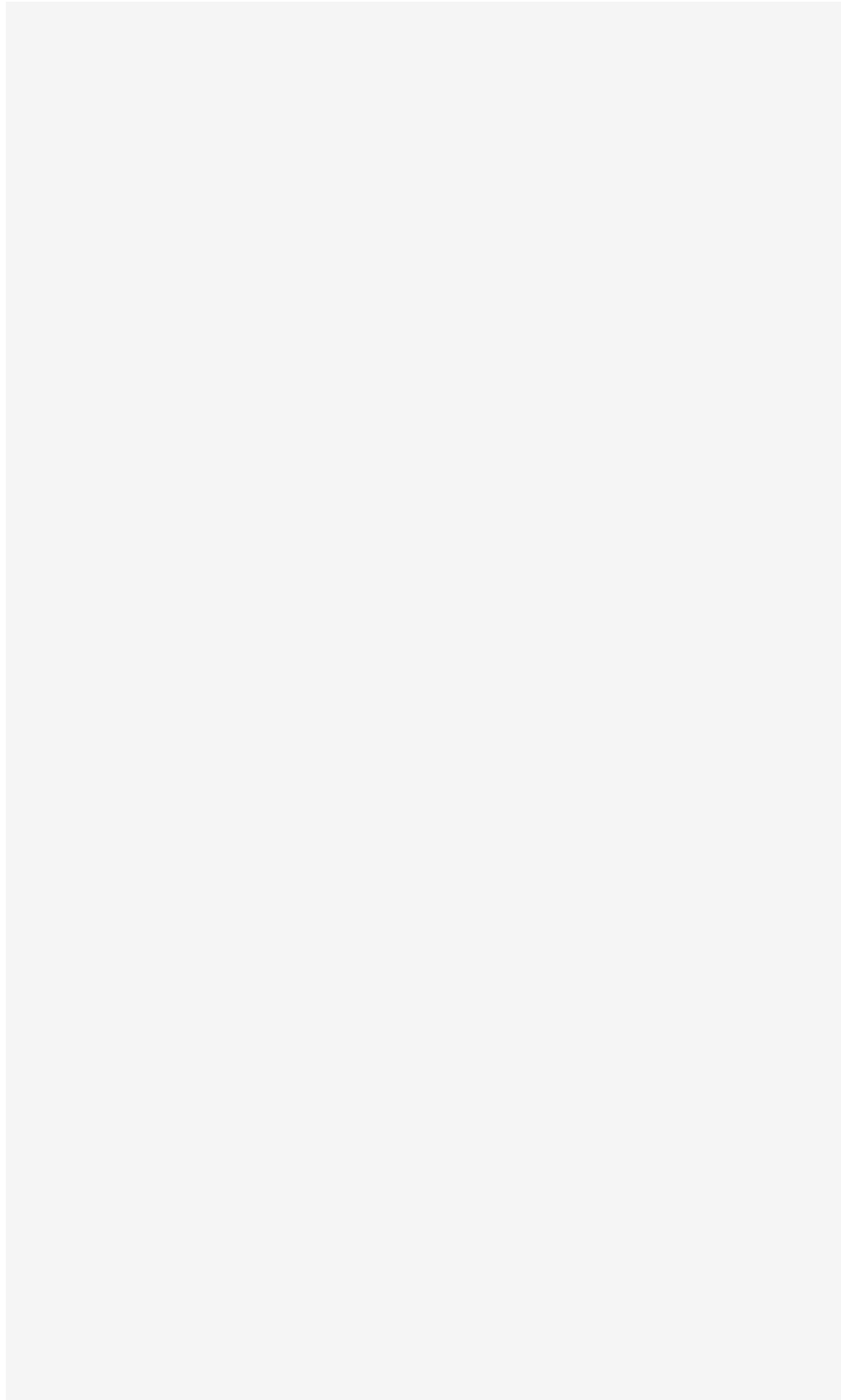


Check if none.

NAME OF VENDOR PRODUCT(S)

**ELIGIBILITY CRITERIA
FOR RN RESIDENCY/
RN FELLOWSHIP
APPLICANTS**

Must include graduation from an accredited RN program, current unencumbered licensure (or international equivalent) as an RN.



SECTION IV: ATTESTATION

Insert your organization's name below, sign, and date electronically. Forms received without a 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 ATTEST, BY MY SIGNATURE BELOW, THAT I AM DULY AUTHORIZED BY:

NAME OF APPLICANT ORGANIZATION

(hereinafter referred to as Applicant Organization) to submit this application for program accreditation offered by the American Nurses Credentialing Center (ANCC) and to make the statements herein. On behalf of Applicant Organization, I have read the Practice Transition Accreditation Program® (PTAP) eligibility requirements and criteria. I understand that Applicant Organization is subject to all eligibility requirements and criteria for accreditation as described in the current Practice Transition Accreditation Program Application Manual and any updates thereto. I understand that program accreditation depends on successfully meeting eligibility requirements and accreditation criteria and that continued accreditation is dependent upon continued compliance. If accredited, the name of Applicant Organization Residency/ Fellowship program will be included in the official listing of ANCC accredited programs with permission.

On behalf of Applicant Organization, by my signature below, I authorize ANCC staff and the Commission on Accreditation of Practice Transition Programs 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.

On behalf of Applicant Organization, 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.

On behalf of Applicant Organization, I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature on behalf of Applicant Organization, that Applicant Organization will comply with all eligibility requirements and accreditation criteria throughout the entire accreditation period, including all reapplication periods for maintaining accreditation, 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 understand that any misstatement of material fact submitted on, with, or in furtherance of this application for program accreditation shall be sufficient cause for ANCC to deny, suspend, or terminate accreditation of Applicant Organization's residency/fellowship program and to take other appropriate action against Applicant Organization.

The following serves as the electronic signature of the individual completing this Application Form and attests to the accuracy of the information provided.

COMPLETED BY

NAME

TITLE

DATE

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