ANCC
AMERICAN NURSES CREDENTIALING CENTER
ACCREDITATION

8515 Georgia Ave, Suite 400
Silver Spring, MD 20910

1.800.284.2378
nursingworld.org/accreditation

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.

Demographics

Program Name:

Include the name of the organization/practice setting/system where the program is operationalized. This name will be used on the program's certificate, plaque, and in the ANCC directory if accredited.

Type of Program:
See the PTAP Application manual for program definitions.

Application Type:
If re-accrediting, please enter the program's PTAP number: _______

Program Mailing Address:

City State Zip Country

Eligibility Verification

Program Director:

Name (as it appears on RN license) and Credentials:

Email: Phone:

License Number: State of Issue:

The RN Residency/RN or APRN Fellowship Program Director holds a current valid license as an RN or APRN, a graduate degree or higher with either the baccalaureate or graduate degree in nursing, and education or experience in adult learning: Yes No

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For applicants outside the U.S.: To validate international credentials, applicants must present verification from CGFNS International (http://www.cgfns.org/) of the Program Director's credentials. ANCC will not accept documentation from other credential evaluating organizations.

The Program Director has the authority within the organization to ensure compliance with ANCC Practice Transition Accreditation Program criteria: Yes No

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

Applicant is in compliance with all applicable local, state, federal, and international laws and regulations that affect the applicant's ability to meet the ANCC Practice Transition Accreditation Program criteria? Yes No

Was program accreditation ever denied, suspended, or revoked by ANCC or any other organization? Yes No

If yes, describe:

Participating Sites

List the sites that participate in the Program and their Site Clinical Coordinators (SCCs), if applicable. Attach an additional page if necessary.

	Site Name	Site Address	SCC Name (as it appears on RN license) and Credentials	License Number	State of Issue
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

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Non-Participating Sites

List the sites that **DO NOT** participate in the Program. Attach an additional page if necessary.

Site Name	Site Address

Scope

List the workplace setting(s) in which residents or fellows are placed (such as medical-surgical, critical care, pediatrics, oncology, etc.). Attach an additional page if necessary.

1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

Attach organizational chart(s) Organizational charts should demonstrate where the program falls within the organization. Clearly identify the Program Director on the chart. If a system-wide (multi-site) program, demonstrate how the organization/sites align to the Program Director and Site Clinical Coordinators (if any).

For multi-site programs only

If the program is provided in more than one site, please provide an executive summary describing how the program is consistently operationalized across all sites.

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Program Information

Executive Summary of the Program

Complete the following descriptions.

Description of the healthcare organization where the program is conducted (500 words or less):

Designation Status:

Magnet® Recognized

Pathway to Excellence® Designated

ANCC Accredited Provider Unit

Brief history and description of the program (500 words or less):

Vendor program used:

Check if None

Vendor Name:_______________________________

Program Length: ______________________

How many residents/fellows have participated in the program in the 12 months preceding the application submission date (including current participants and graduates, regardless of their current status in the organization)? *Note: This will be your program's survey N. At least 51% of this N must respond to the survey in order for the program to move forward in the accreditation process.*
N =

Eligibility criteria for program applicants, which must include graduation from an accredited nursing program, current unencumbered licensure (or international equivalent) as an RN/APRN, and certification as applicable to the program:

Billing

Billing Contact Name:____________________ Email:____________________ Phone:____________________

Billing address if different from mailing address:

____

If successful, would you like a link to your website included in the ANCC directory of accredited practice transition programs? ( ) Yes ( ) No URL:

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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.

I attest, by my signature below, that I am duly authorized by: (insert name of Applicant Organization below)

(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 ____________________

Email completed application to **practicetransition@ana.org**.

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