New Jersey State Nurses Association
Approved Provider Eligibility Verification Form

Section 1: Instructions

1. Complete the Approved Provider Activity Eligibility Verification:

   Cost: $100.00 NJSNA Members $200.00 Non-Member

*The cost above relates to the **Primary Nurse Planner's (PNP) NJSNA MEMBERSHIP STATUS***

2. SEND A COMPLETED COPY OF THE ELIGBILITY FORM AND PAYMENT TO **KJackson@njsna.org.**
   a. The PNP is responsible for the completion of this form and will be held accountable for the verification process.
   b. Payment information is included on the Eligibility Verification Form.
   c. If the form is submitted to the Education Coordinator, its invalid and will not be forwarded to Kortnei Jackson.

3. The actual application will be emailed upon verification of Eligibility and receipt of payment.
   a. If payment is not received, application will not be sent.

Section 2: Eligibility

Applicants interested in submitting an individual educational activity for approval must complete the Eligibility Verification Form. Applicants that do not meet Eligibility Criteria will not be allowed to proceed.

_____
Name of Applicant (Organization)

_____
Street Address

_____
City State Zip/Postal Country

Identify Organization Type:

- ○ State Nurses Association affiliated with ANA
- ○ College or University
- ○ Healthcare Facility (i.e., hospital, rehab center)
- ○ Health - Related Organization (i.e., health department)
- ○ Interprofessional Educational Group (only function is interprofessional continuing education)

◯ Professional Nursing Education Group (only function is continuing nursing education)
◯ Specialty Nursing Organization
◯ Other: Describe - _____

Primary Nurse Planner: Name and Credentials
Employer Title/Position
Telephone Number E-mail Address

- Has the applicant ever been denied approval by or had approval suspended or revoked for an individual activity or a provider application by New Jersey State Nurses Association? ◯ Yes ◯ No

  If yes, please provide the following information:
  Date: Action: ◯ Denial ◯ Suspension ◯ Revocation
  Brief description:

- Has the applicant ever been denied approval by or had approval suspended or revoked for an individual activity or a provider application by another ANCC Accredited Approver?
  ◯ Yes ◯ No

  If yes, please provide the following information:
  Date: Action: ◯ Denial ◯ Suspension ◯ Revocation

  Brief description:

- A currently licensed registered nurse with baccalaureate degree or higher in nursing is actively involved, as the nurse planner, in the planning, implementing and evaluation process of this continuing education activity.
  ◯ Yes ◯ No

Please list the name and credentials of the nurse involved/responsible for this educational activity:

Nurse Planner's Name	**Credentials**

Section 3: Commercial Interest

Is your organization one of the following:

- **If yes, select the option that applies and then go directly to Section 5 (skip Section 4).**
- **If none of the listed types, go to Section 4.**

□ Blood banks,
□ Constituent Member Associations,
□ Diagnostic laboratories,
□ Federal Nursing Services,
□ For-profit and not for profit hospitals,
□ For-profit and not for profit nursing homes,
□ For profit and not for profit rehabilitation centers,
□ Group medical practices,
□ Government organizations,
□ Health insurance providers,
□ Liability insurance providers,
□ National nurses organizations based outside the United States,
□ Non-health care related companies, and
□ Specialty Nursing Organizations
□ A single-focused organization* devoted to offering continuing nursing education (* The single-focused organization exists for the single purpose of providing CNE)

NOTE: 501c applicants are not *automatically* exempt. The ANCC Accreditation Program requires 501c applicants to be screened for eligibility.

____ An "X" on this line identifies the applicant as not exempt from ANCC's definition of a commercial interest. Complete Section 4.

Section 4 – Commercial Interest Evaluation – Only complete this section if you did not select an option for Section 3

A ineligible company: Any entity producing, marketing, reselling or distributing healthcare goods or services consumed by or used on patients or entity that is owned or controlled by an entity that produces, markets, resells, or distributes healthcare goods or services consumed by or used on patients. Exceptions are made for non-profit or government organizations and non-healthcare-related companies.

- Does your organization produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients?

  ◯ Yes **If yes**, the applicant is **not** eligible for approval of Individual Educational Activities.

_____ No **If no**, complete the next bulleted question

- Is your organization owned or controlled by a multi-focused organization (MFO*) that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

  _____ Yes **If yes,** complete the next bulleted question
  _____ No **If no, this section of the questionnaire is complete, proceed to Section 5.**

- Is the applicant a separate and distinct entity from the MFO*?

  _____ Yes - **If yes,** continue to section 4
  _____ No - **If no,** the applicant is **not** a separate and distinct entity from the MFO* then the applicant is **not** eligible for approval of Individual Education Activities.

*** Multi-Focused Organization (MFO) is an organization that exists for more than providing continuing nursing education.**

- Does your organization's owner have 501-C Non-profit Status?
  _____ No **If no**, complete the next bulleted question.
  _____ Yes **If yes**, does your organization's owner advocate for a commercial interest (as defined in Section 3)?

    _____ No
    _____ Yes **If yes**, or not sure, please describe the relationship the commercial interest and the type of work done for or on behalf of the commercial interest. _____

- Is any component of the organization under which you operate an entity that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

  _____ No **If no, this section of the questionnaire is complete, proceed to Section 5**.

  _____ Yes **If yes**, please describe the health care goods or services consumed by or used on patients and the role of the entity in producing, marketing, re-selling or distributing those healthcare goods or services. _____

If yes, please complete and submit the Approved Provider Eligibility Commercial Interest Addendum with this Form

Section 5: Statement of Understanding

On behalf of (insert name of applicant), 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 (insert name of applicant), that (insert name of applicant) will comply with all eligibility requirements and approval criteria throughout the entire approval period, and that (insert name of applicant) will notify New Jersey State Nurses Association) promptly if, for any reason while this application is pending or during any approval period, (insert name of applicant) does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for activity approval shall be sufficient cause for New Jersey State Nurses Association to deny, suspend or terminate (insert name of applicant)'s approval of this individual activity and to take other appropriate action against (insert name of applicant).
(Eligibility Verification forms received without a signature incur a delay in processing which will cause a delay in the review of the individual education activity application.)

A typed name on the line below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information contained.

_____

Completed By: Primary Nurse Planner: Name and Date

Section 6: Payment Information

□ **$100.00 -- NJSNA MEMBER**		□ **$200.00 -- NON-MEMBEES**
METHOD OF PAYMENT:	□ **CHECK ENCLOSED**	□ CREDIT **CARD**
MAKE CHECK PAYABLE TO: ***New Jersey State Nurses Association*** ***1479 Pennington Road, Trenton, NJ 08618***		
NAME ON CARD:		
ADDRESS (*If different from above*):		
CITY:	**STATE**:	**ZIP**:
CREDIT CARD NUMBER:	**EXP. DATE**:	**CVV**:
SIGNATURE:		
Contact: Kortnei Jackson, Administrative Assistant kjackson@njsna.org**, 609-883-5335 x120 (w) 609-883-5343 (f)**		

Please return the completed Eligibility Verification Form to KJackson@njsna.org