New Jersey State Nurses Association
Approved Provider Eligibility Verification

Section 1: 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 - _____

_____

Nurse Planner of the activity: Name and Credentials

_____

Employer Title/Position

_____

Telephone Number E-mail Address

1. **Is your organization a commercial interest?**

A Commercial Interest: *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.*

_____ Yes **You may NOT apply to become/reapply as an Approved Provider.**
_____ No Continue to the next question.

2. Did your organization promote/market/advertise/target more than 50% of your education activities in the past calendar year to registered nurses in Region 2 *(New York, New Jersey, Puerto Rico, Virgin Islands).*

_____ Yes **You may NOT apply to become/reapply as an Approved Provider.**
_____ No Continue to the next question.

Section 2: Nurse Planners

- All Nurse Planners are currently licensed registered nurses with baccalaureate degrees or higher in nursing.
  _____ Yes _____ No

If NO, the applicant organization is **NOT** eligible for Approved Provider status.

- Does the applicant organization have an identified ***Primary Nurse Planner*** who acts as the contact with NJSNA and ensures compliance with ANCC/NJSNA criteria across the Approved Provider Unit?

  Yes No

  If yes, provide Primary Nurse Planner's Name and Credentials: _____

If NO, the applicant organization is **NOT** eligible for Approved Provider status.

- Does the Approved Provider Unit's ***Nurse Planner(s)*** actively participate in the planning, implementation and evaluation process of **each** continuing nursing education activity?

  _____ Yes _____ No

If NO, the applicant organization is **NOT** eligible for Approved Provider status.

Please list the names and credentials of all current nurse planners:

Nurse Planner Name	Credentials

Section 3:

The applicant organization must answer the following questions and providing any additional required information.

- The applicant has been operational for 6 months using the ANCC/NJSNA Criteria.
  _____ Yes **If <u>yes</u>**, list the date the applicant organization became operational: _____
  _____ No **If <u>no</u>**, the applicant organization is **<u>not</u>** eligible for Approved Provider status

- The applicant has assessed, planned, implemented, and evaluated at least three separate educational activities, within the past 12 months, provided at separate and distinct events:
  - with the direct involvement of the Nurse Planner;
  - that adhere to the ANCC Accredited Approver Criteria;
  - each learning activity must be at least 1 hour (60 minutes) in length. Contact hours may or may not have been offered;
  - and were **<u>not</u>** joint provided (new applicants only).

  _____ Yes _____ No

- Applicant organization is in compliance with all applicable Federal, State, and Local laws and regulations that apply to the delivery of CNE.

  _____ Yes _____ No

Section 8: Statement of Understanding

I attest, by my signature below, that I am duly authorized by (Insert name of organization) to submit this application as an approved provider offered by the American Nurses Credentialing Center (ANCC) through Accredited Approvers and to make the statements herein. On behalf of (Insert name of organization), I have read the approved provider eligibility requirements and criteria. I understand that (Insert name of organization) is subject to all eligibility requirements and criteria as an approved provider. I understand that becoming an approved provider depends on successfully meeting eligibility requirements and criteria and maintaining approved provider standing is dependent upon continued compliance.

On behalf of (insert name of organization), I expressly acknowledge and agree that information accumulated through the approval process may be used for statistical, research, and evaluation purposes and that anonymous and aggregate data may be released to third parties. Otherwise, all information will be kept confidential and shall not be used for any other purposes without (insert name of organization)'s permission.

On behalf of (insert name of 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 (insert name of organization), that (insert name of organization) will comply with all eligibility requirements and approval criteria throughout the entire approval period, including all reapplication periods for maintaining approval, and that (insert name of organization) will notify NJSNA promptly if, for any reason while this application is pending or during any approval period, (insert name of organization) does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for approved provider status shall be sufficient cause for NJSNA to deny, suspend or terminate (insert name of organization)'s approved provider status and to take other appropriate action against (insert name of organization). *(Applications received without a signature incur a delay in processing which will cause a delay in the review of the approval application.)*

An "X" in the box below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information contained.

☐ **Electronic Signature (Required)** **Date _____**

_____

Completed By: Name and Title

Please return the completed Eligibility Verification Form and if necessary, the Approved Provider Eligibility Commercial Interest Addendum to NJSNA at: 1479 Pennington Road Trenton, NJ 08618 to Kortnei Jackson at KJackson@njsna.org.