

**New Jersey State Nurses Association**  
**Individual Educational Activity**  
**Applicant 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

## Section 2: Commercial Interest

### Is your organization one of the following:

- If yes, select the option that applies and then go directly to Section 5 (skip Sections 3 & 4).
- If none of the listed types, go to Section 3.
  - 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.

## Section 3 – Commercial Interest Evaluation -- Only complete this section if you did not select an option for Section 2

**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.

- 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.

#### Section 4: Commercial Interest Evaluation

- 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. \_\_\_\_\_

## 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: Nurse Planner of the activity: Name and Date**

**Please return the completed Eligibility Verification Form to [KJackson@njsna.org](mailto:KJackson@njsna.org)**