**NURSE PRACTITIONER & PHYSICIAN ASSISTANT RESIDENCY PROGRAM ACCREDITATION ELIGIBILITY/CANDIDACY FORM**

For nurse practitioner (NP) and physician assistant (PA) residency programs seeking collaborative accreditation by the Accreditation Commission for Education in Nursing (ACEN) and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

To be eligible for NP & PA Residency Program Accreditation a residency program must meet the eligibility requirements as outlined in Policy 303: Eligibility for Initial and Continuing of Nurse Practitioner and Physician Assistant Residency Programs. NP & PA Residency Program Accreditation polices, standards, criteria with glossary and fee schedule can be found here on the ACEN/ARC-PA webpage

([www.nppa-accredit.org](http://www.nppa-accredit.org/))

**SPONSORING ORGANIZATION:**

Institution Name:

Location of Institution:

Our advanced practice provider program is established in a: (check all that apply)

[ ] school of allopathic or osteopathic medicine

[ ] college/university affiliated with appropriate clinical teaching facilities

[ ] medical education facility of the federal government

[ ] hospital, medical center or ambulatory clinic

[ ]  other as approved by the governing boards for the ACEN and/or ARC-PA

Chief Administrative Officer

Name and Credentials

Institutional Title

Address 1

Address 2

City, State and Zip

Email

Phone

Institutional Accreditation/Recognition

NP & PA Residency Program is established in a sponsoring organization that is recognized/accredited by: (check all that apply)

[ ] school of allopathic or osteopathic medicine

[ ] college/university affiliated with appropriate clinical teaching facilities

[ ] medical education facility of the federal government

[ ] hospital, medical center or ambulatory clinic

[ ] Accreditation Association for Ambulatory Health Care (AAAHC)

[ ] American Osteopathic Association (AOA)

[ ] Commission on Accreditation of Rehabilitative Facilities (CARF)

[ ] DNV Healthcare

[ ] Healthcare Facilities Accreditation Program

[ ] Middle States Association of Colleges and Schools

[ ] New England Association of Schools and Colleges

[ ] North Central Association of Colleges and Schools

[ ] Northwest Association of Schools and Colleges

[ ] Southern Association of Colleges and Schools

[ ] Schools Western Association of Schools and Colleges

[ ] The Joint Commission

[ ] Higher Learning Commission (HLC)

[ ]  other as approved by the governing boards for the ACEN and/or ARC-PA

Date and Outcome of Last Accreditation/Recognition

(Attach a copy of most recent action)

Organizational Structure

Include a copy of the Organizational Chart for the Sponsoring Organization and the NP & PA Residency Program (must clearly identify the reporting structure)

**NP & PA RESIDENCY PROGRAM INFORMATION:**

Official Program Name

Clinical Specialty Discipline(s)

Administrative Location Address:

Anticipated program implementation date (if applicable):

Anticipated number of trainees (if applicable):

Residency Program Administration(s):

Name and Credentials

Institutional Title

Address 1

Address 2

City, State and Zip

Email

Phone

Date NP & PA Residency Program first accepted trainees (if applicable)

Length of NP & PA Residency Program:

NP & PA trainee acceptance schedule (e.g., annual, quarterly, rolling):

Number of NP & PA trainee cohorts accepted each year: \_\_\_\_ NP \_\_\_\_ PA

Current number of NP & PA trainees: \_\_\_\_ NP \_\_\_\_ PA

**Program Educators:**

|  |
| --- |
| **Name prefix: ￼**Choose an item **First name:** Enter first name **Middle name (or initial):** Enter middle name **Last Name:** Enter last name **Academic credentials:** Enter credentials**Program title:** Enter title **FTE% with program:** Enter %**Address:** Enter address Enter city, Enter state Enter zip**Phone #:** Enter phone #**E-mail address:** Enter email address |

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| **Name prefix:** Choose an item **First name:** Enter first name **Middle name (or initial):** Enter middle name **Last Name:** Enter last name **Academic credentials:** Enter credentials**Program title:** Enter title **FTE% with program:** Enter %**Address:** Enter address Enter city, Enter state Enter zip**Phone #:** Enter phone #**E-mail address:** Enter email address |

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**Staff:**

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| **Name prefix:** Choose an item **Name:** Enter name  **Program title:** Enter title **Phone #:** Enter phone #**E-mail address:** Enter email address**FTE% with program:** Enter % |

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**Other relevant Institutional or program data that you wish to include:**

Enter text

**Curriculum Sequence**

**Complete** Part A and Part B

**PART A**

Present a schematic representation of the program components and their sequences in the horizontal spaces as appropriate using the template below.

|  |
| --- |
| **L** Lectures, seminars |
| **C** Case conferences/grand rounds |
| **R**  Clinical experiences (rotations) |
| **V** Vacation/Time off |

**Note:** Begin the table in the top row with the month your program begins. Be sure to add the month abbreviation. Place the curriculum categories that occur in the boxes for the months and years of the program. (See sample below).

| **SAMPLE Curriculum (program begins in July)** |
| --- |
| YR | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | June |
| ***1*** | ***L*** | ***L*** | ***L*** | ***L*** | ***C*** | ***C*** | ***C,R*** | ***L,C,R*** | ***R*** | ***R*** | ***R*** | ***R*** |
| ***2*** | ***R*** | ***V*** | ***C,R*** | ***L,C,E*** | ***C,R*** | ***R*** | ***R*** |  |  |  |  |  |
| ***3*** |  |  |  |  |  |  |  |  |  |  |  |  |

| **YOUR PROGRAM’S CURRICULUM** |
| --- |
| YR | Mth  | Mth  | Mth  | Mth  | Mth  | Mth  | Mth  | Mth  | Mth  | Mth  | Mth  | Mth  |
| ***1*** | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  |
| ***2*** | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  |
| ***3*** | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  | Enter  |

Comments: Click here to enter text

**PART B**

**Didactic Courses and Clinical Rotations**

List **all** required and elective **didactic courses or sessions and clinical experiences (rotations)**, listing required experiences before electives. For each, indicate the number of contact hours and indicate the instructional methods used.

| **Course, Rotation** |  | **Instructional Methods** |
| --- | --- | --- |
|  | Number of contact hours | Lectures / Seminars | Group discussions | Online coursework | Simulation | Clinical skills lab | Laboratory | Problem based learning | Self-instructional module | Program educators/site visit | Interaction with preceptors | Other: (Describe in comment below) |
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Comments: Enter text

I have read the Nurse Practitioner & Physician Assistant Residency Program Accreditation Program Standards 1st edition, June 2023, Effective January 2024, Revised January, 2024

([www.nppa-accredit.org)](http://www.nppa-accredit.org/)

Select yes/no

[ ]  I attest that the NP & PA Residency Program and Sponsoring Organization has sufficient financial, human, and physical facilities resources to operate the educational program and fulfil the program’s obligations to matriculated trainees.

[ ]  I attest understanding that the NP & PA Residency Program and Sponsoring Organization must pay the ACEN/ARC-PA accreditation and associated fees as determined by the ACEN/ARC-PA.

I understand that the program will be subject to denial of accreditation and denial of future eligibility for accreditation in the event that any of the statements or answers made in this document or the application are false or in the event that the program violates any of the policies governing applicant programs.

Form submitted by:

 Name

*The name entered above is deemed an electronic signature.*

Title: Title

Date: Date

Form completed by:

 Name

*If different than person submitting. The name entered above is deemed an electronic signature.*

Title:

Date: Date

Form approved by:

 Name

*Authorized agent of the sponsoring organization (e.g., CEO, CMO, CNO). The name entered above is deemed an electronic signature.*

Title: Title

Date: Date