**Nursing Skills Competency Program – Intent to Apply**

**Section 1: Organization Information**

Name of Organization Providing the Nursing Skills Competency Course:

Address:

City:       State:       Zip/Postal:

Country:

Phone:

Point of Contact (Name and Credentials):

Address (if different from above):

City:       State:       Zip/Postal:

Country:

Phone:       Fax:

E-mail:

For applicants outside the US: To validate international credentials, applicants must present verification from CGFNS International (<http://www.cgfns.org/>). ANCC will not accept verification documents from other credential evaluating organizations.

Date Form Completed:

Type of Organization:

Hospital/health care facility

Education company

Commercial interest organization

Specialty nursing organization

University/college

Other (specify):

**Section 2: Course Overview and Assessment of Eligibility**

Name of nursing skills competency course:

*(****Note****: The course title may not include language that implies an individual successfully completing a recognized Nursing Skills Competency Course is individually certified in a skill or skill set. Therefore the terms “certification” and “certified” may not be used in the title of a course submitted for recognition. The term “certificate” is considered acceptable.)*

Initial application for recognition

Re-application for currently recognized course

* + Has the applicant ever been denied course recognition, or had a course suspended or revoked?

No

Yes

* + - * If yes, please explain:

Geographic Service Area (check all that apply)

Local  National

State  International

Regional

Length of Existence of Program:

New

Established (year)

How many individual are expected to participate in the course annually?

*Renewal of Recognition applicants only:*

* 1. How many individuals attempted to complete the course in the last 12 months?
  2. How many individuals successfully completed the course in the last 12 months?

**Section 3: Executive Summary of Course**

Provide a short executive summary on the course include describe the skill, goals of completion of the course, and audience.

**Section 4: Statement of Understanding**

*Insert name of applicant in the spaces provided, then sign and date as indicated at bottom of the form.*

I attest, by my signature below, that I am duly authorized by (     ) to submit this application for course recognition offered by the American Nurses Credentialing Center (ANCC) and to make the statements herein. On behalf of (     ), I have read the recognition eligibility requirements and criteria. I understand that (     ) is subject to all eligibility requirements and criteria for course recognition. I understand that recognition depends on successfully meeting eligibility requirements and NSCP course recognition criteria and that continued course recognition is dependent upon continued compliance. If the course is recognized, (     )’s name and course title will be included in the official listing of ANCC's Nursing Skills Competency Program recognized course list.

On behalf of, (     ), by my signature below, I authorize ANCC staff and the Commission on Accreditation 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.

On behalf of (     ), I expressly acknowledge and agree that information accumulated by ANCC through the recognition 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 (     )’s permission.

On behalf of (     ), I hereby certify that (     ) is in compliance with all Local, State, Federal and International laws and regulations relevant to this course.

On behalf of (     ), I hereby certify that, if the course is recognized by the Commission on Accreditation, (     ) will make no modifications to the course following recognition without express written approval from the Director of Accreditation.

On behalf of (     ), 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 (     ), that (     ) will comply with all eligibility requirements and course recognition criteria throughout the entire recognition period, including all reapplication periods, and that (     ) will notify ANCC promptly if, for any reason during, (     ) does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for recognition shall be sufficient cause for ANCC to deny, suspend or terminate (     )’s course(s) recognition and to take other appropriate action against (     ).

*(Applications received without a signature incur a delay in processing which will cause a delay in the review of the NSCP course recognition application.)*

An “X” in the box below serves as the electronic signature of the individual completing this NSCP Course Recognition Application and attests to the accuracy of the information contained.

**Electronic Signature (Required) Date:**

**Completed By: Name and Title:**

Please complete and electronically return to: [accreditation@ana.org](mailto:accreditation@ana.org)

The Accreditation Program Office will verify your program’s eligibility for the Nursing Skills Competency Program application process.

After receiving verification of eligibility, allow approximately 12 weeks to complete your program’s Course Recognition Application Form. Submit the Course Recognition Application Form along with any supporting documentation to [accreditation@ana.org](mailto:accreditation@ana.org).