Application for a Certified Registered Nurse Practitioner Education Program

GENERAL INSTRUCTIONS

- For purposes of this application, the Provider is the controlling institution that awards the degree.
- For purposes of this application, the Contact Person is the author of the proposal and with whom the Board will communicate on behalf of the CRNP Program. The Contact Person and the Program Director may be the same.
- A separate application must be submitted for each degree type within each population specialty. A Post-Master’s option does not necessitate a separate application.
- At the time the application is submitted, the Program must either identify the Program Director and the Nursing Faculty or detail the qualifications required for these positions provided that the regulations do not require that the positions are filled.
- All applications must be reviewed by the Board at a regularly scheduled meeting. Applications will be placed on the agenda once the application is complete and any deficiencies have been corrected.
- If seeking an additional educational site beyond the one(s) approved by the Board, complete a separate application for each additional location. If content (curriculum, policies etc.) requested on the template form(s) is unchanged from the Board approved program indicate that on the form in the section where the related attachment is requested. Do NOT attach a copy of the previously approved materials.

FEES

- The $735.00 non-refundable application fee must be submitted for each degree type within each population specialty. The fee must accompany the application.
- Applications that are incomplete one year from receipt in the Board office must be resubmitted with a new application fee.

FORMAT

- Where citations are required, use established citation format. For example, Author, S. P. (Year of publication). Title of work: Capital letter also for subtitle. Location: Publisher.
- Submit the original and three copies of the application and attachments.
- Submit attachments on 8.5x11 size paper, double-spaced and single-sided.
- Number every page consecutively including the page dividing each attachment.
ATTACHMENTS - The following documents must be labeled and attached with this application:

- Attachment 1: Provider’s Philosophies and Objectives
- Attachment 2: Provider’s Organizational Chart depicting the relationship with the CRNP Program
- Attachment 3: Provider’s Letter of Commitment to the CRNP Program
- Attachment 4: Pennsylvania Department of Education’s Authorization to offer a degree in the planned specialty
- Attachment 5: CRNP Program’s Philosophies and Objectives
- Attachment 6: CRNP Program’s Organizational Chart
- Attachment 7: CRNP Program’s Faculty Policies on:
  - Orientation
  - Faculty Responsibilities
  - Faculty Development
  - Evaluation
  - Faculty Organization Minutes Retention
  - Record Management
  - Maintaining expertise in clinical/functional area(s) of specialization
  - Selection and Retention of Preceptors
- Attachment 8: CRNP Program’s Student Policies on:
  - Admission and Selection
  - Advanced Standing
  - Retention
  - Progression
  - Refunds
  - Record Maintenance
- Attachment 9: Curriculum Plan By Semester - Template A
  - Only one degree to be awarded can be submitted with each application. Include a separate curriculum plan by semester for the full-time, part-time or Post-Master’s option.
- Attachment 10: Syllabi for each course on the Curriculum Plan to include:
  - Hours of instruction broken down into didactic, clinical, laboratory and simulation hours
  - Faculty member’s name
  - Course name and number
  - Course pre- and co-requisites
  - Course credits
  - Course description
  - Course objectives
  - Course content outline per week
  - Required and recommended textbooks/references
  - Technology requirements
  - Methods of course delivery (lecture, discussion boards, online)
Assessment tools and methods including the grading matrix and clinical
evaluation

- Attachment 11: Course Objectives to National Educational Standards Crosswalk
- Attachment 12: Systematic Evaluation Plan
  An organized, continuous analysis of all CRNP program components, such as curriculum, faculty, facilities, policies and outcome measures to include outcomes of graduates at 1 and 3-year intervals, that addresses standards or benchmarks to be achieved and establishes an action plan if those standards or benchmarks are not achieved.
- Attachment 13: Sample Faculty Evaluations and Student Evaluations for clinical and theory
- Attachment 14: Facility and Resource Plan
  Describe the planned office, instructional and administrative support, clinical laboratories, library facilities, technology and resources, as well as equipment for the CRNP Program.
- Attachment 15: Program Director’s CV and transcripts. The CV shall detail the Program Director’s experience practicing and teaching, including the courses taught and the number of years teaching, and administering/operating an education program. If the Program Director does not possess a doctoral degree also include the plan to obtain the doctoral degree within five years.
- Attachment 16: CV for each Nursing Faculty member
- Attachment 17: Copies of Affiliation Agreements/Letters of Intent from the cooperating agencies identified indicating a positive commitment to the CRNP program and the availability of sufficient resources to meet the educational requirements of the CRNP program.
- Attachment 18: 5-Year Projected Nursing Faculty to Student Complement Per Year and Term - Template B
- Attachment 19: 5-Year Budget Projection of Financial Viability
  An Excel spreadsheet setting forth the details required for the 5-year budget projection is available on the Board's website.
Application for a Certified Registered Nurse Practitioner Education Program

Provider Information
Provider’s Name: ________________________________________________________________

Provider’s Mailing Address: _________________________________________________________

Provider’s Physical Address: _________________________________________________________

Provider’s Telephone Number: ________________ Provider’s Web Address: ________________

Web Link to the Provider’s Catalogue: _______________________________________________

Provider’s Accreditor:

___Regional Accrediting Agency

___Other (Explain) ________________________________________________________________

CRNP Program Information

CRNP Specialty Sought (Select One):

_____ Adult-Gerontology Acute Care       _____ Adult-Gerontology Primary Care

_____ Family/Individual Across the Lifespan      _____ Neonatal

_____ Pediatric Acute Care         _____ Pediatric Primary Care

_____ Psychiatric-Mental Health      _____ Women’s Health/Gender-Related

Other _____________________________________________________________

CRNP Program’s Name: ___________________________________________________________

CRNP Program’s Mailing Address: __________________________________________________

CRNP Program’s Physical Address: ________________________________________________

Degree to be awarded for the planned specialty (Select One Degree):

_____ Master’s Degree                 _____ Doctorate

_____ Full-time                      _____ Full-time

_____ Part-time                      _____ Part-time

Other _____________________________________________________________
Do you plan to offer a Post-Master’s option? ______ Yes ______ No

CRNP Program’s Intended Admission Date of Students: __________________________________________________________

Anticipated Accreditor:

______ACEN ________CCNE ________CNEA

Other ____________________________________________________________

Anticipated Nurse Practitioner Examination Eligibility: (Select All That Apply)

______American Academy of Nurse Practitioners (AANP)
______American Association of Critical Care Nurses (AACN)
______American Nurses Credentialing Center (ANCC)
______National Certification Corporation (NCC)
______Oncology Nursing Certification Corporation (ONCC)
______Pediatric Nursing Certification Board (PNCB)

Other ____________________________________________________________

Anticipated Nurse Practitioner Examination Specialty: (Select All That Apply)

______Adult-Gerontology Acute Care
______Adult-Gerontology Primary Care
______Family/Individual Across the Lifespan
______Neonatal
______Pediatric Acute Care
______Pediatric Primary Care
______Psychiatric-Mental Health
______Women’s Health/Gender-Related

Other ____________________________________________________________

Policies

Are the faculty and student policies of the CRNP program at least equal to those of the provider’s other programs?

______ Yes ______ No (Explain)__________________________________________

Web Link to the CRNP Program’s Faculty Handbook: __________________________________________________________

Web Link to the Graduate Student Handbook: __________________________________________________________

Contact Person Information

Contact Person Name: __________________________________________________________

1-30-18
Contact Person Physical Address: __________________________________________________________

Contact Person Telephone Number: ________________________________________________________

Contact Person Email Address: ____________________________________________________________

**Education Information**

Rationale--Provide state and local statistical data to support the need for the CRNP program and to assure the availability of an adequate number of interested candidates. Cite all references in APA format.

_______________________________________________________

Using the courses listed on the Curriculum Plan by Semester, identify by course number the following content:

- Research ________________________________________________________________
- Health Care Policy and Organization __________________________________________
- Ethics ____________________________________________________________________
- Professional Role Development ______________________________________________
- Theoretical Foundations of Nursing Practice ____________________________________
- Human Diversity and Social Issues __________________________________________
- Health Promotion and Disease Prevention ______________________________________
- Advanced Health/Physical Assessment _________________________________________
- Advanced Physiology and Pathophysiology ______________________________________
- Advanced Pharmacology _____________________________________________________
- Specialty Content __________________________________________________________
Identify the specific National Educational Standard(s) used to develop the curriculum—Examples of curriculum development standards include AACN The Essentials of Master’s Education in Nursing or The Essentials of Doctoral Education for Advanced Nursing Practice, National Organization of Nurse Practitioner Faculties (NONPF) Nurse Practitioner Core Competencies or Population-Focused Nurse Practitioner Competencies or the Criteria for Evaluation of Nurse Practitioner Programs.

Simulation Program Plan

Cite the specific standard(s) used to develop the simulation program

Describe the resources, including faculty, budgetary, facility and equipment, for the simulation program

Faculty Information

PROGRAM DIRECTOR

Have you Identified a Program Director for this program?

Yes – Go directly to Identified Program Director questions.
No – Go directly to Minimum Qualifications for the Program Director questions.

Identified Program Director

Program Director’s PA RN License Number: ________________________________

Program Director’s PA CRNP Certification Number: ________________________________

Program Director’s Name: ________________________________

Program Director’s PA CRNP Specialty: ________________________________

Program Director’s PA CRNP Certification Expiration Date: ________________________________

Program Director’s Telephone Number: ________________________________
Program Director’s Academic Credentials

Program Name: ____________________________

City/State: ________________________________

Degree and Year Awarded:

__________PhD    _________EdD    __________DNSc    __________DNP/DrNP

_________Other ____________________________

Program Director’s Nurse Practitioner National Certification Organization: (Select All That Apply)

_______ American Academy of Nurse Practitioners (AANP)

_______ American Association of Critical Care Nurses (AACN)

_______ American Nurses Credentialing Center (ANCC)

_______ National Certification Corporation (NCC)

_______ Oncology Nursing Certification Corporation (ONCC)

_______ Pediatric Nursing Certification Board (PNCB)

_______ Other ________________________________

Program Director’s Nurse Practitioner National Certification with Specialty__________________________

Program Director’s Nurse Practitioner National Certification Expiration Date: ____________________

Program Director’s Jurisdiction(s) of Licensure: ________________________________________________

Program Director’s Appointment Status: _______ Interim_______ Permanent

Program Director is also teaching

_______ Yes - If the Program Director is also teaching, include the Program Director as a faculty member in the section below.

_______ No

Program Director’s Date of Appointment ____________________________
Minimum Qualifications for the Program Director

The Program Director of a CRNP program must have at least one graduate degree in nursing and a doctoral degree or have a specific plan for completing doctoral preparation within five years of appointment and hold a PA RN license and a CRNP Certificate. Detail the Program’s minimum qualifications for its Program Director, including the minimum education, teaching and/or operating a program experience, licensure requirements, and job description.

Detail the minimum qualifications for the Program Director for this Program

____________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________

FACULTY MEMBERS
Do you have identified faculty for this program?

• Yes – Go directly to Identified Faculty questions.
• No – Go directly to Minimum Qualifications for Faculty

Identified Faculty

Faculty Member’s PA RN License Number:_______________________________________________________________

If teaching clinical courses, Faculty Member’s PA CRNP Certification Number: __________________________

Faculty Member’s Name:_______________________________________________________________

If teaching clinical courses, Faculty Member’s PA CRNP Specialty: __________________________

Faculty Member’s Teaching Responsibilities: (Select All That Apply)

__________Clinical  ___________Theory

Faculty Member’s Academic Credentials

Program Name:_______________________________________________________________

City/State:_______________________________________________________________

Highest Degree and Year Awarded Related to the Subject Matter:

__________PhD  ___________EdD  ___________DNSc  _____DNP

__________MSN  ___________MS  _______Master’s in Nursing Education

__________Post-Master’s in Nursing  _______Master’s in Other Field
If teaching a clinical course, Faculty Member’s Nurse Practitioner National Certification organization: (Select All That Apply)

- American Academy of Nurse Practitioners (AANP)
- American Association of Critical Care Nurses (AACN)
- American Nurses Credentialing Center (ANCC)
- National Certification Corporation (NCC)
- Oncology Nursing Certification Corporation (ONCC)
- Pediatric Nursing Certification Board (PNCB)
- Other

If teaching a clinical course, Faculty Member’s Nurse Practitioner National Certification with Specialty:

__________________________________________________________________________

If teaching a clinical course, Faculty Member’s Nurse Practitioner National Certification Expiration Date:

__________________________________________________________________________

Faculty Member’s Employment Status:

- Part-time
- Full-time
- Adjunct

Faculty Member’s Date of Appointment ____________________________________________________________________________

Faculty Member’s Title/Position __________________________________________________________________________________

Courses being taught by Faculty Member ___________________________________________________________________________

Add a separate attachment for additional Faculty.

Minimum Qualifications for the Faculty

The CRNP faculty must have expertise in their subject areas and be currently licensed. Clinical faculty must also be currently certified as a CRNP, maintain National Certification, and be engaged in ongoing clinical practice in this Commonwealth.

Detail the minimum qualifications for the CRNP Faculty teaching theory for this Program

_________________________________________________________________________________________________________________

1-30-18
Detail the minimum qualifications for the CRNP Clinical Faculty for this Program

Detail the minimum qualifications for the CRNP Non-Nursing Faculty for this Program

PRECEPTORS

*Preceptors for CRNP Programs may be physicians, CRNPs and advanced practice nurses each of whom must be currently licensed, and in the case of CRNPs, also currently certified.*

Preceptor’s Name: _____________________________________________________________

Preceptor’s License/CRNP Certification Number: __________________________________________

Preceptor’s License Status: _________________________________________________________

Preceptor’s CRNP Specialty: _________________________________________________________

Preceptor’s State of Licensure (Only provide the licensure for the state where the precepting is taking place.): _____________________________________________________________

Add a separate attachment for additional preceptors

*Compile a list of preceptors along with the facilities wherein the students will engage with live patients to obtain clinical experience with a preceptor under the supervision of the faculty member assigned to the clinical course. In addition to providing the name and the city/state of the facility, identify the patient population and the type of facility from the following categories:*

- Nursing homes
- Ambulatory services
- Hospitals
- Home Health
- Physician/Practitioner Office
- Other

<table>
<thead>
<tr>
<th>Name of Preceptor</th>
<th>Name of Facility</th>
<th>City/State</th>
<th>Patient Population</th>
<th>Description of Facility</th>
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1-30-18
I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911. I also verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration or the denial/restriction of the approval to be a CRNP program.

Signature of Program Application Contact Person________________________  Date ____________
**Template A**  
**CURRICULUM PLAN BY SEMESTER**

### Semester I:

<table>
<thead>
<tr>
<th>Course and Title</th>
<th>Term</th>
<th>Type and hours of instruction</th>
<th>Total # hours of Instruction</th>
<th>Board Approved Course</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Didactic Clinical Lab Sim</td>
<td>Clock Credit</td>
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**Total**  

### Semester II:

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<th>Course and Title</th>
<th>Term</th>
<th>Type and hours of instruction</th>
<th>Total # hours of instruction</th>
<th>Board Approved Course</th>
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<tbody>
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**Total**  

### Semester III:

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<th>Course and Title</th>
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<th>Type and hours of instruction</th>
<th>Total # hours of instruction</th>
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**Total**  

### Semester IV:

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<th>Term</th>
<th>Type and hours of instruction</th>
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<tbody>
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**Total**

**TOTAL NUMBER OF HOURS**  
(ALL SEMESTERS)  

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<th>Clinical</th>
<th>Lab</th>
<th>Sim</th>
<th>Clock hours</th>
<th>Credit</th>
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1-30-18
## Template B
### 5 YEAR PROJECTED FACULTY TO STUDENT COMPLEMENT PER YEAR AND TERM

<table>
<thead>
<tr>
<th></th>
<th>Projected student enrollment</th>
<th>Projected faculty complement</th>
<th>Faculty/Student Ratio For Clinical Courses</th>
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<tbody>
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<td>New</td>
<td>Continuing and Returning</td>
<td>Full Time</td>
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