Notice: Application fee was increased on July 27, 2019.

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 $2195.00 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
  
  o Attachment 11: Course Objectives to National Educational Standards Crosswalk
  
  o 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.

  o Attachment 13: Sample Faculty Evaluations and Student Evaluations for clinical and theory

  o 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.

  o 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.

  o Attachment 16: CV for each Nursing Faculty member

  o 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.

  o Attachment 18: 5-Year Projected Nursing Faculty to Student Complement Per Year and Term - Template B

  o 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; Revised 7/2019
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 ________________________________________________________
  _______________________________________________________________________

1-30-18; Revised 7/2019
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

1-30-18; Revised 7/2019
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; Revised 7/2019
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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</thead>
<tbody>
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</table>

1-30-18; Revised 7/2019
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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Didactic Clinical Lab Sim</td>
<td>Clock Credit</td>
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Total

#### Semester II:

<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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Didactic Clinical Lab Sim</td>
<td>Clock Credit</td>
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</tbody>
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Total

#### Semester III:

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<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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<tbody>
<tr>
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<td>Didactic Clinical Lab Sim</td>
<td>Clock Credit</td>
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Total

#### Semester IV:

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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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<td>Didactic Clinical Lab Sim</td>
<td>Clock Credit</td>
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Total

### TOTAL NUMBER OF HOURS (ALL SEMESTERS)

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<th>Lab</th>
<th>Sim</th>
<th>Clock hours</th>
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1-30-18; Revised 7/2019
# Template B
## 5 Year Projected Faculty to Student Complement Per Year and Term

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<tr>
<th>Year</th>
<th>New</th>
<th>Continuing and Returning</th>
<th>Full Time</th>
<th>Part Time</th>
<th>Faculty/Student Ratio for Clinical Courses</th>
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