



**PENNSYLVANIA STATE BOARD OF NURSING
P.O. BOX 2649
HARRISBURG, PA 17105-2649**

Office Use Only
College: _____
Specialty: _____

PHONE: (717)783-7142
www.dos.pa.gov/nurse

email: st-nurse@pa.gov

CHANGE OF CNS PROGRAM NAME

A separate form must be submitted for each program. Do not fax.

College/University: _____

College/University regionally accredited YES NO

Anticipated Date of Current Program Closure: _____

Anticipated Date of Proposed Program to Begin: _____

	Current	Proposed
CNS Program Name:	_____	_____
Degree or Certificate Conferred:	_____	_____
National Accreditation and Date:	_____	_____
National Specialty Certification:	_____	_____
National Specialty Certification Organization:	_____	_____

Date	Original Signature of Program Director
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Phone number	Print Name and Title of Program Director
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