Program Information Form

Nurse Practitioner Fellowship/Residency Programs

**General Information:**

Organizational Nurse Practitioner Fellowship/Residency Program Name:

Official Name of Partnering Healthcare Organization:

Type of Institution:

Academic medical center

Teaching hospital

Community hospital

Rural hospital

System with multiple hospitals that includes at least 1 academic medical center

System with multiple hospitals that does not include an academic medical center

Military hospital

VA hospital

Ambulatory care clinic

Long-term care facility

Primary care facility

Urgent care clinic

Community health center

Other (describe):

Official Name of Partnering Academic Program:

Type of Institution:

Public

Private, secular

Private, religious

Proprietary

Managing Entity for the program (check one):

healthcare organization academic institution

# of individual programs pursuing CCNE accreditation:

Name of individual program(s) (list each program separated by commas):

Website address of program (list multiple separated by commas if applicable):

**Program Leadership:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Full Name and Title | Street Address | City, State, Zip Code | Email | Phone and Fax |
| Chief Executive Officer (for managing entity) |  |  |  |  |  |
| Chief Nursing Officer/Chief Nurse Executive (for partnering healthcare org) |  |  |  |  |  |
| Chief Nurse Administrator (for partnering academic program) |  |  |  |  |  |
| Fellowship  /Residency Director |  |  |  |  |  |

**Institutional Accreditation:**

|  |  |
| --- | --- |
| **Institutional Accreditor**  *(identify institutional accrediting agency name for* ***both*** *the partnering healthcare organization* ***and*** *the partnering academic institution,*  *e.g. The Joint Commission, Higher Learning Commission)* | **Current Status**  *(e.g., full accreditation, provisional, warning, show cause)* |
|  |  |
|  |  |

If the current accreditation status of the institution is anything other than full accreditation, please provide to CCNE a copy of the institutional accrediting agency’s most recent accreditation action letter. Also provide (below) an explanation of the current status and how the NP fellowship/residency program is impacted and/or implicated, if at all:

**Programmatic Accreditation:**

|  |  |
| --- | --- |
| **Programmatic Accreditor**  *(identify agency name for the partnering academic nursing program,*  *e.g. Commission on Collegiate Nursing Education)* | **Current Status**  *(e.g., full accreditation, provisional, warning, show cause)* |
|  |  |
|  |  |

If the current accreditation status of the partnering academic nursing program is anything other than full accreditation, please provide to CCNE a copy of the accrediting agency’s most recent accreditation action letter. Also provide (below) an explanation of the current status and how the NP fellowship/residency program is impacted and/or implicated, if at all:

NP Fellowship/Residency Program Information:

**Length of Program** (add additional rows If needed):

|  |  |  |
| --- | --- | --- |
| Program Name | Year Program Became Operational | **Length of Program in Months** |
|  |  |  |
|  |  |  |

**Fellow/Resident Data** (provide up to 3 years of data per program, add additional rows if needed):

|  |  |  |  |
| --- | --- | --- | --- |
| Program Name | Program Year | **# Fellows/Residents Enrolled** | **# Completed Program** |
| (Name of Program 1) |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| (Name of Program 2) |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Describe the organizational relationship between the individual programs identified above, including, but not limited to, administrative control and leadership:**

**Additional Sites:**

Identify any additional sites where the NP fellowship/residency program is offered, the distance from the main location, and the average number of fellows/residents currently enrolled at each location.

|  |  |  |
| --- | --- | --- |
| **Site**  *(City, State)* | **Distance From Main Location**  *(in miles)* | **# Fellows/Residents Enrolled** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Check here** to verify that the Chief Nurse of the managing entity, identified above, has approved this completed form and confirms its contents as of      . (date)