ANCC
AMERICAN NURSES CREDENTIALING CENTER
ACCREDITATION

PRACTICE TRANSITION ACCREDITATION PROGRAM®

nursingworld.org/organizational-programs/accreditation/ptap

8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910
1.800.284.2378

PRACTICE TRANSITION ACCREDITATION PROGRAM®

APPLICATION FORM

Complete all sections and submit via email to practicetransition@ana.org.

NOTE: Your program will receive an invoice upon approval of this application. The application fee must be paid in full prior to the accreditation decision.

SECTION I: DEMOGRAPHICS

PROGRAM NAME

Include the name of the organization/practice setting/system where the program is operationalized. If accredited, this name will be used on the program's certificate, plaque, and in the ANCC directory if accredited.

ORGANIZATION NAME

Specify name of the organization/health system where learners practice.

TYPE OF PROGRAM

- [ ] RN Residency
- [ ] RN Fellowship

TYPE OF APPLICATION

- [ ] Initial Accreditation
- [ ] Re-Accreditation

If re-accrediting, enter the program's PTAP number:

PROGRAM MAILING ADDRESS

STREET

CITY | STATE | ZIP

COUNTY

COUNTRY | TIME ZONE

APM-FRM-261, PTAP 2024 Application Form, Rev. 4, 5/21/24
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SECTION I: DEMOGRAPHICS (CONTINUED)

WEBSITE

If accredited, would you like your website link in the ANCC directory of accredited practice transition program?

☐ Yes ☐ No

If yes, list URL here:

CNO/CMO AND CREDENTIALS (System CNO for multi-site programs)

NAME

CREDENTIALS

EMAIL

PHONE

SECTION II: ELIGIBILITY VERIFICATION: PROGRAM DIRECTOR, RESIDENTS/FELLOWS, PARTICIPATING SITES AND PRACTICE SETTINGS

PROGRAM DIRECTOR

The RN Residency/RN Fellowship Program Director holds a current valid license as an RN, a graduate degree or higher (either the baccalaureate or graduate degree must be in nursing or international equivalent), and has education or experience in adult learning.

☐ Yes ☐ No

NAME

CREDENTIALS

EMAIL

PHONE

LICENSE NUMBER

STATE OF ISSUE

MASTER'S DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

YEAR OF GRADUATION

NAME OF UNIVERSITY

LOCATION (CITY/STATE)

BACCALAUREATE DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

YEAR OF GRADUATION

NAME OF UNIVERSITY

LOCATION (CITY/STATE)

See the *2024 PTAP Application Manual* for eligibility requirements. The PTAP/APPFA Team may ask for verification of education or experience in adult learning principles.

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PROGRAM ELIGIBILITY

The Program Director has the accountability and oversight of all participating sites and practice settings, educational design process, and agrees to serve as the primary point of contact with the PTAP/APPFA office.

At least one cohort has graduated from the program: Yes No

YEAR/MONTH PROGRAM STARTED	PROGRAM LENGTH (MONTHS)	YEAR/MONTH FIRST COHORT GRADUATED

The applicant:

Has evidence that learners will be paid at least the applicable minimum wage (according to Federal, State, and local requirements or international equivalents) and are not required to pay to participate in the program.

Yes No

Abides by the Equal Employment Opportunity (EEO) policy to ensure freedom from discrimination on the basis of protected classes such as race, color, sex, national origin, religion, age, disability or genetic information.

Yes No

Is in compliance with all applicable local, state, federal, and international laws and regulations that affect the applicant's ability to meet the ANCC PTAP criteria.

Yes No

Was the program accreditation ever denied, suspended, or revoked by ANCC or any other organization?

Yes No If yes, describe:

NUMBER OF LEARNERS FOR SURVEY

How many learners have participated in the program during the 12 months preceding the application form submission (include current participants and graduates, regardless of their current status in the organization).

N =

This will be your program's survey N. At least 51% of this N must respond to the survey for the program to move forward in the accreditation process. The N only includes learners from eligible sites and practice setting(s).

PARTICIPATING SITES

List the eligible sites that participate in the Program and corresponding Site Coordinators (SCs), if applicable. Utilize the *Application Addendum Form* if the program has more than 5 eligible participating sites. Each site within a program must be from the same healthcare system. The maximum size of an accreditable program is up to 30 sites. See the *2024 PTAP Application Manual* for definitions and eligibility details. In summary site requirements include:

- A **minimum of one** learner must have **completed** the program in full at the site to be eligible for accreditation:
  - — New applicants must have a minimum of one learner complete the program at each site within the 24-months (2-year period) prior to the application form submission;
  - — Reaccrediting programs must have a minimum of one learner complete the program at each site within the 48-months (4-year period) prior to the application form submission.

SITE COORDINATOR

- In a *multisite, multi-practice setting* program **11 sites or larger**, each site **must** have a Site Coordinator (SC). The SC must have a direct or dotted line of authority to the Program Director. The PD **may not** be a SC.
- In a *multisite, multi-practice setting* program of **2-10 sites**, each site **may** have a Site Coordinator (SC). The SC must have a direct or dotted line of authority to the Program Director. The PD **may** be a SC.
- In a *multisite, single practice setting* program, each site **may** utilize Site Coordinators (SC) to ensure program consistency. The PD **may** be a SC.
- SCs must maintain a current, valid license as an RN, hold a baccalaureate degree or higher in nursing, and have education and/or experience in adult learning principles.

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PARTICIPATING SITES

(MULTISITE, MULTI-PRACTICE SETTING PROGRAMS 11 SITES OR LARGER, EACH SITE MUST HAVE A SITE COORDINATOR)

1

SITE NAME

STREET

CITY STATE ZIP GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES. Yes No

LICENSE NUMBER

STATE OF ISSUE

HIGHEST DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

2

SITE NAME

STREET

CITY STATE ZIP GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES. Yes No

LICENSE NUMBER

STATE OF ISSUE

HIGHEST DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

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SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES. Yes No

LICENSE NUMBER | STATE OF ISSUE

HIGHEST DEGREE (CREDENTIALS CONFERRED) | DATE CONFERRED

4

SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES. Yes No

LICENSE NUMBER | STATE OF ISSUE

HIGHEST DEGREE (CREDENTIALS CONFERRED) | DATE CONFERRED

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SITE NAME

STREET

CITY | STATE | ZIP | GEOGRAPHIC LOCATION

SITE COORDINATOR (IF APPLICABLE) - REQUIRED FOR MULTISITE, MULTI-PRACTICE SETTING PROGRAMS WITH 11+ SITES

SITE COORDINATOR NAME (AS IT APPEARS ON RN LICENSE) AND CREDENTIALS

SC HAS EDUCATION AND/OR EXPERIENCE IN ADULT LEARNING PRINCIPLES. Yes No

LICENSE NUMBER

STATE OF ISSUE

HIGHEST DEGREE (CREDENTIALS CONFERRED)

DATE CONFERRED

NON-PARTICIPATING SITES

List the sites that **DO NOT** participate in the Program. *Attach the Application Addendum Form if program has more than 5 non-participating sites.*

1 SITE NAME

2 SITE NAME

3 SITE NAME

4 SITE NAME

5 SITE NAME

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ORGANIZATIONAL CHARTS

☐ Check box to confirm email attachment of Organizational Chart for your Organization/ Healthcare System.

1 Organization/Healthcare System Chart

- Demonstrate the relationship of key leaders within the organization
- Include all participating sites for a multi-site program
- CNO/CMO (System-level for multi-site programs)
- Key program stakeholders

-Names, roles, and credentials should be included on charts for key program stakeholders.

☐ Check box to confirm email attachment of Organizational Chart for RN Residency/ Fellowship.

2 RN Residency/Fellowship Organizational Chart

- Clearly identify the RN residency/fellowship program leadership
- Represent RN residency/fellowship structure and key stakeholders
  -Names, roles, and credentials should be included on charts for key program stakeholders.
- For *multisite, multi-practice setting* programs with **11 sites or larger,** each site **must** have a Site Coordinator (SC) with a direct or dotted line of authority to the Program Director. The PD **may not** be a SC.
- For *multisite, multi-practice setting* programs with **2-10 sites**, each site **may** have a SC. The SC must have a direct or dotted line of authority to the PD. The PD **may** be a SC.
- In a *multisite, multi-practice setting* program, each eligible practice setting functioning in multiple sites **must** have a centralized person, called the Practice Setting Coordinator (PSC). The PSC must have a dotted or direct line of authority to the PD.

FOR SINGLE-SITE PROGRAMS ONLY

Skip to page 9 if multi-site program.

Number of Learners in Application Review Timeframe*

1. Indicate the name of the Practice Setting Coordinator (PSC), if applicable, in the first column. In a single site, multi-practice setting program, Practice Setting Coordinators (PSC) **may** be utilized to ensure program consistency.
2. Denote which practice setting(s) are eligible for accreditation review by indicating the year the program started in the second column of the table on page 8:
   a. Refer to practice setting(s) definitions in the *2024 PTAP Application Manual*, Appendix A, to ensure proper classification of practice setting(s) into approved categories.
3. Indicate how many learners have participated in each practice setting(s) during the application review timeframe by placing a number in the third column of the table on page 8:
   a. *New programs must indicate the number of learners in each practice setting during the 24-months (2-year period) prior to the application form submission.
   b. *Reaccrediting programs must indicate the number of learners in each practice setting during the 48 months (4-year period) prior to the application form submission.
   c. A minimum of one learner must have completed the program at each practice setting included on this application within the 24-month or 48-month time frame prior to application submission.

ELIGIBILITY REMINDER: A ***minimum of one*** learner must have completed the program ***at the site*** to be eligible for accreditation. Additionally, a ***minimum of one*** learner must have completed the program ***within the practice setting*** to be eligible for accreditation.

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Only add numbers under eligible practice setting(s).
If ineligible, please keep the box blank. Do not put "N/A" or "0".

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

PRACTICE SETTING (PS)	PRACTICE SETTING COORDINATOR (NAME AND CREDENTIALS) *Optional* for single site, multi-practice setting programs.	YEAR PROGRAM STARTED AT PRACTICE SETTING	NUMBER OF LEARNERS IN APPLICATION REVIEW TIMEFRAME
Medical			
Surgical			
Medical-Surgical			
Oncology			
Step Down			
Critical Care			
Labor & Delivery			
Ante/Postpartum			
Labor, Delivery, Recovery and Postpartum (LDRP)			
Neonatal Intensive Care Unit (NICU)			
Pediatrics			
Pediatric Intensive Care Unit (PICU)			
Operating Room			
Post Anesthesia Recovery Unit (PACU)			
Same Day/Ambulatory Procedure			
Psychiatric			
Rehabilitation			
Ambulatory			
Emergency Department			
Specialty Practice Provide name(s) of Specialty			
Acuity Adaptable (Universal Bed)			
Long Term Care			
Preoperative			
Home Care			
Hospice			
Centralized Function			
Other — Contact PTAP/AFFPA Team.			
Total # of Learners per Practice Setting(s) in Review Timeframe			

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FOR MULTI-SITE PROGRAMS

Skip to page 12 if single-site program.

PROGRAM CONSISTENCY

Provide an executive summary describing how the program is consistently operationalized across all sites (500 words or less).

NUMBER OF LEARNERS IN APPLICATION REVIEW TIMEFRAME*

1. List each site included on application pages 4, 5, and 6 under the "site name" row in accordance with organization names provided prior.
2. Denote which practice setting(s) are eligible for accreditation review by indicating the year the program started in the second column of the table on pages 10 through 13:
   a. Refer to practice setting(s) definitions in the *2024 PTAP Application Manual*, Appendix A, to ensure proper classification of practice setting(s) into approved categories.
3. Indicate how many learners have participated in each practice setting(s) during the application review timeframe by placing a number in the second column of the table on pages 10 through 13.
   a. *New programs must indicate the number of learners in each practice setting during the 24-months (2-year period) prior to the application form submission.
   b. *Reaccrediting programs must indicate the number of learners in each practice setting during the 48 months (4-year period) prior to the application form submission.
   c. A minimum of one learner must have completed the program at each practice setting included on this application within the 24-month or 48-month time frame prior to application submission.
4. Indicate the name of the Practice Setting Coordinator (PSC), if applicable. In a multisite, multi-practice setting program, each eligible practice setting functioning in **multiple sites** must have **a (one) centralized person**, called the Practice Setting Coordinator (PSC), coordinating the practice setting curriculums across all sites within the program.
   a. PSCs must maintain a current, valid license as an RN, hold a baccalaureate degree or higher in nursing, and have education and/or experience in adult learning principles.
   b. PSCs must have expertise in the specialty they represent.

ELIGIBILITY REMINDER: A *minimum of one* learner must have completed the program *at the site* to be eligible for accreditation. Additionally, a *minimum of one* learner must have completed the program *within the practice setting* to be eligible for accreditation.

Attach the Application Addendum Form if program has more than 5 sites.

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Only add numbers under eligible practice settings. If ineligible, please keep the box blank. Do not put "N/A" or "0".

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

Each eligible practice setting functioning in **multiple sites** MUST have only ONE identified Practice Setting Coordinator (PSC) coordinating the practice setting curriculum across all sites within the program. Each PSC must have expertise in the specialty they represent. See 2024 ANCC PTAP Manual (Chapter 2) and Manual Addendums.

SITE NAME	1.		2.		3.		Practice Setting Coordinator (PSC)		
PRACTICE SETTINGS (PS)	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Does this practice setting function in more than one location? (Y/N)	PSC Name and Credentials (Only one PSC allowed per practice setting)	PSC meets eligibility requirements and has expertise in specialty they represent
Medical									Yes
Surgical									Yes
Medical-Surgical									Yes
Oncology									Yes
Step Down									Yes
Critical Care									Yes
Labor & Delivery									Yes
Ante/Postpartum									Yes
Labor, Delivery, Recovery and Postpartum (LDRP)									Yes
Neonatal Intensive Care Unit (NICU)									Yes
Pediatrics									Yes
Pediatric Intensive Care Unit (PICU)									Yes
Operating Room									Yes
Post Anesthesia Recovery Unit (PACU)									Yes
Same Day/Ambulatory Procedure									Yes
Psychiatric									Yes
Rehabilitation									Yes
Ambulatory									Yes
Emergency Department									Yes
Acuity Adaptable (Universal Bed)									Yes

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PRACTICE SETTINGS (PS)	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Does this practice setting function in more than one location? (Y/N)	PSC Name and Credentials (Only one PSC allowed per practice setting)	PSC meets eligibility requirements and has expertise in specialty they represent
Specialty Practice (provide name(s) of Specialty)									Yes
Long Term Care									Yes
Preoperative									Yes
Home Care									Yes
Hospice									Yes
Centralized Function									Yes
Other — Contact PTAP/AFFPA Team.									Yes
Total # of Learners per Practice Setting(s) in Review Timeframe									

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Each eligible practice setting functioning in multiple sites MUST have only ONE identified Practice Setting Coordinator (PSC) coordinating the practice setting curriculum across all sites within the program. Each PSC must have expertise in the specialty they represent. See 2024 ANCC PTAP Manual (Chapter 2) and glossary terminology.

SITE NAME	4.		5.		Practice Setting Coordinator (PSC)		
PRACTICE SETTINGS (PS)	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Does this practice setting function in more than one location? (Y/N)	PSC Name and Credentials (Only one PSC allowed per practice setting)	PSC meets eligibility requirements and has expertise in specialty they represent
Medical							Yes
Surgical							Yes
Medical-Surgical							Yes
Oncology							Yes
Step Down							Yes
Critical Care							Yes
Labor & Delivery							Yes
Ante/Postpartum							Yes
Labor, Delivery, Recovery and Postpartum (LDRP)							Yes
Neonatal Intensive Care Unit (NICU)							Yes
Pediatrics							Yes
Pediatric Intensive Care Unit (PICU)							Yes
Operating Room							Yes
Post Anesthesia Recovery Unit (PACU)							Yes
Same Day/Ambulatory Procedure							Yes
Psychiatric							Yes
Rehabilitation							Yes
Ambulatory							Yes
Emergency Department							Yes
Acuity Adaptable (Universal Bed)							Yes

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PRACTICE SETTINGS (PS)	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Year Program Started at Practice Setting	Number of Learners in Application Review Timeframe	Does this practice setting function in more than one location? (Y/N)	PSC Name and Credentials (Only one PSC allowed per practice setting)	PSC meets eligibility requirements and has expertise in specialty they represent
Specialty Practice (provide name(s) of Specialty)							Yes
Long Term Care							Yes
Preoperative							Yes
Home Care							Yes
Hospice							Yes
Centralized Function							Yes
Other — Contact PTAP/AFFPA Team.							Yes
Total # of Learners per Practice Setting(s) in Review Timeframe							

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ANCC DESIGNATION STATUS

Provide the following information for your healthcare organization or program.

- Magnet® Recognized
- Pathway to Excellence® Designation
- APPFA™ Accredited
- Joint Accreditation ™
- ANCC Accredited Provider Unit (Provider unit differs from approver unit; only provider status will be confirmed.)

ORGANIZATION DESCRIPTION

Brief description of the **healthcare organization** and/or **health system** (if applicable) (500 words or less).

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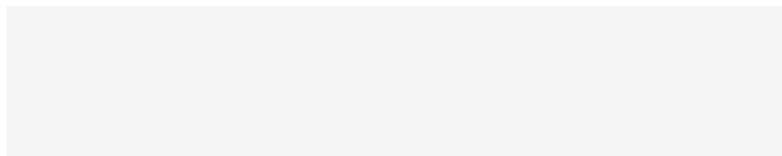
BRIEF HISTORY AND DESCRIPTION OF THE RN RESIDENCY/ RN FELLOWSHIP SEEKING ACCREDITATION

(500 words or less)

VENDOR PRODUCTS USED



Check if none.

NAME OF VENDOR PRODUCT(S)

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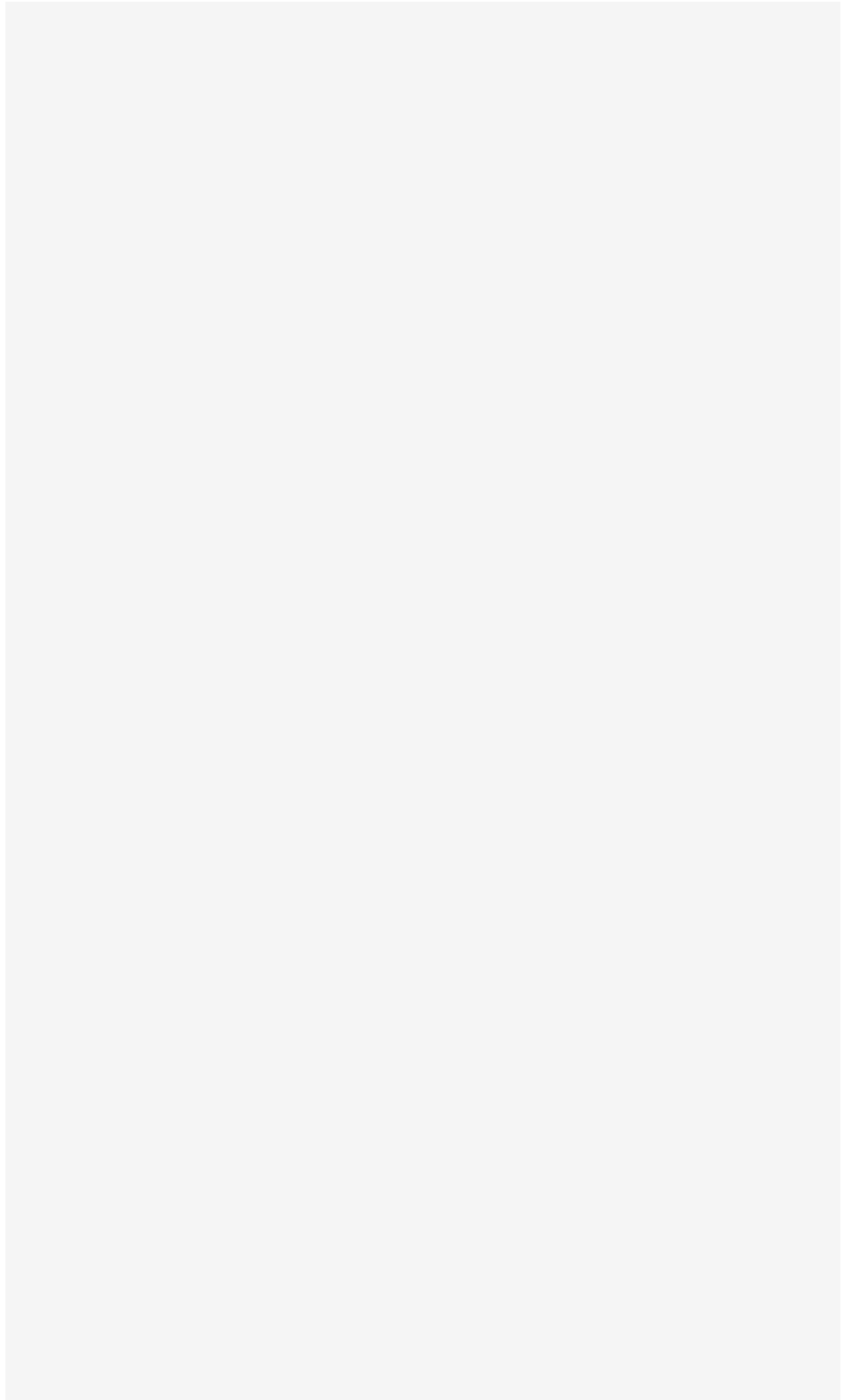
ELIGIBILITY CRITERIA FOR RN RESIDENCY/ RN FELLOWSHIP APPLICANTS

Must include graduation from an accredited RN program, current unencumbered licensure (or international equivalent) as an RN.



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SECTION IV: ATTESTATION

Insert your organization's name below, sign, and date electronically. Forms received without a signature incur a delay in processing which will cause a delay in the review of the accreditation application.

IMPORTANT: Please **do not lock** the application form when applying your electronic signature. ANCC requires submission of an unlocked document and will return all locked applications for resubmission.

I ATTEST, BY MY SIGNATURE BELOW, THAT I AM DULY AUTHORIZED BY:

NAME OF APPLICANT ORGANIZATION

(hereinafter referred to as Applicant Organization) to submit this application for program accreditation offered by the American Nurses Credentialing Center (ANCC) and to make the statements herein. On behalf of Applicant Organization, I have read the Practice Transition Accreditation Program® (PTAP) eligibility requirements and criteria. I understand that Applicant Organization is subject to all eligibility requirements and criteria for accreditation as described in the current Practice Transition Accreditation Program Application Manual and any updates thereto. I understand that program accreditation depends on successfully meeting eligibility requirements and accreditation criteria and that continued accreditation is dependent upon continued compliance. If accredited, the name of Applicant Organization Residency/Fellowship program will be included in the official listing of ANCC accredited programs with permission.

On behalf of Applicant Organization, by my signature below, I authorize ANCC staff and the Commission on Accreditation of Practice Transition Programs 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, subject to applicable policies, laws, or regulations.

On behalf of Applicant Organization, I expressly acknowledge and agree that information accumulated by ANCC through the accreditation 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 Applicant Organization's permission.

On behalf of Applicant Organization, 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 Applicant Organization, that Applicant Organization will comply with all eligibility requirements and accreditation criteria throughout the entire accreditation period, including all reapplication periods for maintaining accreditation, and that Applicant Organization will notify ANCC promptly if, for any reason while this application is pending or during any accreditation period, Applicant Organization does not maintain compliance. I understand that any misstatement of material fact submitted on, with, or in furtherance of this application for program accreditation shall be sufficient cause for ANCC to deny, suspend, or terminate accreditation of Applicant Organization's residency/fellowship program and to take other appropriate action against Applicant Organization.

The following serves as the electronic signature of the individual completing this Application Form and attests to the accuracy of the information provided.

COMPLETED BY

NAME

TITLE

DATE

Complete all sections and submit via email to practicetransition@ana.org.

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