Colorado Nurses Association
Approved Provider Eligibility Form

Intent to Apply or Reapply
Rev 02. 2022

Thank you for your interest in applying or reapplying to be a provider of nursing continuing professional development through CNA. Please use this form to enable us to verify your initial or continued eligibility.

Section 1: Demographic Data

Organizations interested in submitting an application for approval as an Approved Provider must complete the Eligibility Form and meet all eligibility requirements.

Applicants that do not meet Eligibility Criteria will not be allowed to proceed.

Name of Your Organization Date _____

☐ Currently approved provider Yes No

☐ New applicant

Street Address

City State Zip/Postal Country

Identify Organization Type:

____Constituent Member Associations of ANA
____College or University
____Healthcare Facility
____Health - Related Organization
____Multidisciplinary Educational Group
____Professional Nursing Education Group
____Specialty Nursing Organization
____Other

Primary Point of Contact:

Primary Nurse Planner & Credentials (Must have a BSN)

Title/Position Telephone Number

Email

- Our organization is in compliance with all applicable Federal, State, and Local laws and regulations that apply to the delivery of CNE.
  ☐ Yes ☐ No

Section 2: Nurse Planners

- All Nurse Planners are currently licensed registered nurses with baccalaureate degrees or higher in nursing.
  ☐ Yes ☐ No (If no, contact the CNA Program Director)

- A Nurse Planner from the list below (or the primary nurse planner) is an active participant in the planning, implementing and evaluation process of ***each*** continuing education activity.
  ☐ Yes ☐ No (If no, contact the CNA Program Director)

Please list the names and credentials of all current nurse planners:

Nurse Planner Name	Credentials

Section 3: Regional Target Market

- If you are a Colorado-based provider, in the past year, was the target market for at least 50% of your activities located ***within*** the states of Montana, North Dakota, South Dakota, Wyoming, Colorado, Utah, Nevada, Arizona, New Mexico, Idaho, Nebraska, or Kansas? For region information, refer to https://www.hhs.gov/about/agencies/iea/regional-offices/index.html

- If you are an applicant from another state, in the past year, was the target market for at least 50% of your activities located ***within*** the states that are part of your region? Contact CAN for information regarding your region.

☐ Yes	**If yes**, proceed to section 4
☐ No	If no, the applicant organization is not eligible for Approved Provider may be eligible for Accredited Provider status. (For more information, refer to: www.nursecredentialing.org/Accreditation). Contact the CNA Program Director for assistance.

Section 4: This Section for New Applicants Only; Currently approved providers please proceed to section 5.

Please answer the following questions and provide any additional required information.

- This organization has been operational for 6 months using the ANCC Accreditation Criteria.
  - ☐ Yes **If yes**, list the date your organization began offering contact hours, based on activities that have been approved by CNA:
  - ☐ No **If no**, your organization is **not** eligible for Approved Provider status

- This organization has assessed, planned, implemented, and evaluated at least three separate educational activities, within the past 12 months, provided at separate and distinct events:
  - with the direct involvement of a qualified Nurse Planner;
  - that adhere to the ANCC Accreditation Criteria as specified by CNA;
  - that were approved by CNA or another accredited approver;
  - each learning activity must be at least 1 hour (60 minutes) in length;
  - and must have been provided independently (**not** co-provided)

  ☐ Yes ☐ No (If no, please contact the CNA Program Director)

Section 5: Commercial Interest – If you have questions about any of this information, please contact CNA Program Director.

The following section is intended to collect information about your organization's corporate structure. Some organization types are *automatically* exempt from ANCC's definition of a commercial interest, including:

- Blood banks,
- State Nurses Association **affiliated with ANA**
- Diagnostic laboratories,
- Federal Nursing Services,
- For-profit and not for profit hospitals,
- For-profit and not for profit nursing homes,
- For profit and not for profit rehabilitation centers,
- Group medical practices,
- Government organizations,
- Health insurance providers,
- Liability insurance providers,
- National nurses organizations based outside the United States,
- Non-health care related companies, and
- Specialty Nursing Organizations
- A single-focused organization* devoted to offering continuing nursing education

* The Single-Focused Organization exists for the single purpose of providing CNE.

NOTE: 501c organizations are not *automatically* exempt. The ANCC Accreditation Program requires 501c organizations to be screened for eligibility.

____ **An "X" on this line identifies your organization as exempt from ANCC's definition of a commercial interest. Identify your organization's exemption type from section 2 above and enter it here:** _____

If you checked the box above, then you have completed this questionnaire and should proceed to Section 8.

Section 6 - Only complete this section if your organization is not exempt

☐ **An "X" on this line identifies your organization as not exempt from the ANCC Accreditation Program's definition of a commercial interest.** The following questions must be answered so the Colorado Nurses Association's Accredited Approver Unit can assess your organization's eligibility.

- Does your organization produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients?
  - ☐ Yes **If yes**, your organization is **not** eligible for Approved Provider status
  - ☐ No **If no, complete the next bulleted question.**

- Is your organization owned or controlled by a multi-focused organization (MFO*) that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?
  - ☐ Yes **If yes, complete the next bulleted question**.
  - ☐ No **If no,** you have completed this questionnaire and should proceed to Section 8.

- Is your organization a separate and distinct entity from the
  - ☐ MFO*? Yes - **If yes, continue to section 7**
  - ☐ No - **If no,** your organization is **not** a separate and distinct entity from the MFO*, so the organization is **not** eligible for Approved Provider status.

* Multi-Focused Organization (MFO) is an organization that exists for more than providing continuing nursing education.

Section 7

Does the multi-focused organization that owns your organization have a 501-C Non-Profit Status? Yes No

If yes, does the company that owns your organization advocate for a commercial interest (as defined by the ANCC Accreditation Program?)

☐ Yes **If yes**, or you are not sure, please describe the relationship the company that owns your organization has with a commercial interest and the types of work the company that owns your organization does for or on behalf of a commercial interest that might be considered advocacy. ___

☐ No

- Is any component of the multi-focused organization an entity that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

  ☐ Yes **<u>If yes</u>**, please describe the health care good or service consumed by or used on patients and the role of the entity in producing, marketing, re-selling or distributing those healthcare goods or services. _____

  ☐ No **<u>If no</u>**, you have completed this questionnaire, proceed to Section 8.

<u>If yes</u>, please contact CNA for further information. Additional clarification of your organization's eligibility will be required.

Section 8: Statement of Understanding

I attest, by my signature below, that I am duly authorized by (Insert name of your organization) to apply to CNA as an approved provider under the American Nurses Credentialing Center (ANCC) accreditation criteria and to make the statements herein. On behalf of my organization, I have read the approved provider eligibility requirements and criteria. I understand that my organization is subject to all eligibility requirements and criteria as an approved provider. I understand that becoming an approved provider depends on successfully meeting eligibility requirements and criteria and maintaining approved provider standing is dependent upon continued adherence.

On behalf of my organization, I expressly acknowledge and agree that information accumulated through the approval process may be used for statistical, research, and evaluation purposes and that anonymous and aggregate data may be released to third parties. Otherwise, all information will be kept confidential and shall not be used for any other purposes without my organization's permission.

On behalf of my organization, I hereby certify that the information provided on and with this document is true, complete, and correct. I further attest, by my signature on behalf of my organization, that this organization and provider unit will comply with all eligibility requirements and approval criteria throughout the entire approval period, including all reapplication periods for maintaining approval, and that our organization will notify CNA's Approver Unit promptly if, for any reason while this application is pending or during any approval period, our organization does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of the application for approved provider status shall be sufficient cause for CNA to deny, suspend or terminate our organization's approved provider status and to take other appropriate action against the organization.

(Failure to provide a signature will result in a delay in processing which will cause a delay in the review of the approval application.)

An "X" in the box below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information contained.

☐ **Electronic Signature (Required)** **Date**

_____

Completed By: Name and Title

The Primary Nurse Planner is held accountable for all information provided on this form.
Thank you for completing this form.

CNA Program Director: Nan Morgan, RN, BSN, MS

Info@coloradonurses.org

For office use only:

Date eligibility form received: _____
Eligible to apply for initial provider approval: **Yes** ☐ **No** ☐
Eligible to apply for provider re approval: **Yes** ☐ **No** ☐

If not eligible, why not:

Date of Review_____**Reviewer** Click here to enter text.

Date applicant notified of eligibility: _____ **Notified by** _____