

# Practice Transition Accreditation Program



[nursingworld.org/organizational-programs/accreditation/ptap](https://nursingworld.org/organizational-programs/accreditation/ptap)

8403 Colesville Road, Suite 500  
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](mailto: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 RN Residency or RN Fellowship program. If accredited, this name will be used on the program's certificate, plaque, and in the ANCC directory.

#### ORGANIZATION NAME

Specify the 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

SECTION I: DEMOGRAPHICS (CONTINUED)

WEBSITE

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

☐ Yes ☐ No

If yes, list URL here:

CNO/CMO AND CREDENTIALIALS (If a multi-site program, provide name of system CNO)

<div></div>	<div></div>
NAME	CREDENTIALIALS
<div></div>	<div></div>
EMAIL	PHONE

SECTION II: ELIGIBILITY VERIFICATION: PROGRAM DIRECTOR, LEARNERS, 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 and/or experience in adult learning.

☐ Yes ☐ No

<div></div>	<div></div>	
NAME	CREDENTIALIALS	
<div></div>	<div></div>	
EMAIL	PHONE	
<div></div>	<div></div>	
LICENSE NUMBER	STATE OF ISSUE	
<div></div>	<div></div>	<div></div>
GRADUATE DEGREE (CREDENTIALIALS CONFERRED)	DATE CONFERRED	YEAR OF GRADUATION
<div></div>	<div></div>	
NAME OF UNIVERSITY	LOCATION (CITY/STATE)	
<div></div>	<div></div>	<div></div>
BACCALAUREATE DEGREE (CREDENTIALIALS CONFERRED)	DATE CONFERRED	YEAR OF GRADUATION
<div></div>	<div></div>	
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.

## SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

### 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

<input type="text"/>	<input type="text"/>	<input type="text"/>
MONTH/YEAR PROGRAM STARTED	PROGRAM LENGTH (MONTHS)	MONTH/YEAR 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

Indicate how many learners have participated in the program during the 12 months preceding the application form submission (this 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 site(s) 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.

## SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

### PARTICIPATING SITES

(NOTE: 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

## SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

3

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

SECTION II: ELIGIBILITY VERIFICATION (CONTINUED)

5

SITE NAME

STREET

CITYSTATEZIPGEOGRAPHIC 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.

YesNo

LICENSE NUMBERSTATE 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

ORGANIZATIONAL CHARTS

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

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

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.

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 10](#) if a 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, PSCs **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 time frame 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.

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) <small>Optional for single site, multi-practice setting programs.</small>	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 <small>Provide name(s) of Specialty</small>			
Acuity Adaptable (Universal Bed)			
Long Term Care			
Preoperative			
Home Care			
Hospice			
Centralized Function			
Other — Contact PTAP/APPFA Team.			
Total # of Learners per Practice Setting(s) in Review Timeframe			



FOR MULTI-SITE PROGRAMS

Skip to [page 14](#) 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 time frame 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 multi-site, 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.

## 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 <u>one</u> 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

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 <u>and</u> 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/APPFA Team									Yes
Total # of Learners per Practice Setting(s) in Review Timeframe									

## 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 glossary terminology.

SITE NAME	4.		5.		Practice Setting Coordinator (PSC)		
	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

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/APPFA Team.							Yes
Total # of Learners per Practice Setting(s) in Review Timeframe							

ANCC DESIGNATION STATUS

Provide the following information for your healthcare organization or program.

<input type="checkbox"/> Magnet® Recognized	<input type="checkbox"/> Pathway to Excellence® Designation	<input type="checkbox"/> APPFA™ Accredited
<input type="checkbox"/> Joint Accreditation™ (Joint Accreditation differs from Joint Commission)	<input type="checkbox"/> ANCC Accredited Provider Unit (Provider unit differs from approver unit; only provider status will be confirmed.)	<input type="checkbox"/> ANCC Well-Being Excellence™

ORGANIZATION DESCRIPTION

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

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

(500 words or less)

**VENDOR  
PRODUCTS USED**

NAME OF VENDOR PRODUCT(S)

☐ Check if none.

**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.



## SECTION IV: ATTESTATION

Insert your name, title, and organization name below electronically. Forms received without the required information will 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 \_\_\_\_\_ [Name], \_\_\_\_\_ [Title] of  
\_\_\_\_\_[Organization] (hereinafter referred to as Applicant Organization),  
attest, by my signature below, that I am duly authorized to submit this application on behalf of the Applicant  
Organization for program accreditation offered by the American Nurses Credentialing Center (ANCC) and to make the  
statements herein.

On behalf of Applicant Organization, I acknowledge and agree to the following:

- I have reviewed and understand the Practice Transition Accreditation Program® (PTAP) eligibility requirements and criteria as described in the current Practice Transition Accreditation Program Application Manual and any addendums to the manual posted on the Practice Transition Accreditation Program's website (collectively, PTAP Manual), incorporated herein by reference.
- I understand and agree that Applicant Organization will comply with all eligibility requirements and accreditation criteria throughout the application phase, the review phase, and accreditation period, 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 have reviewed and understand the PTAP application and appraisal review process as described in the PTAP Manual, incorporated herein by reference, which controls the review, decision making and accreditation process for PTAP.
- I have reviewed, understand, and agree to the PTAP investment fee structure and terms outlined in detail at <https://www.nursingworld.org/organizational-programs/accreditation/ptap/ptap-accreditation-fees/> and in the PTAP Manual, incorporated herein by reference.
- I understand and agree that all fees and outstanding balances owed to PTAP must be paid in full prior to receipt of an accreditation decision as described in the PTAP Manual and incorporated herein by reference.
- I understand and agree that failure to pay fees when due or failure to make arrangements to pay fees will result in action against an applicant or PTAP accredited organization's credential, up to and including denial of an application, suspension, or revocation of accreditation, as described in the PTAP Manual and incorporated herein by reference.
- I understand and agree that all fees are deemed earned on the date payment is due.
- I understand and agree that any disputes regarding invoices should be raised with ANCC prior to payment. Payment of the invoice shall be proof of acceptance of the classification of the Applicant Organization for billing purposes and acceptance of the fees therein.
- I understand and agree that submission of an application or completion of the processes outlined in the PTAP Manual does not, in and of itself, guarantee PTAP accreditation.

## SECTION IV: ATTESTATION

Insert your name, title, and date below electronically. Forms received without an electronic 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 understand and agree, if accredited, the name of Applicant Organization Residency/Fellowship Program will be included in the official listing of ANCC accredited programs with permission.
- I authorize ANCC staff and the Commission on Accreditation of Practice Transition Programs (COA-PTP) 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.
- 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.
- I understand and agree that the written documentation will be the original, unique work of the Applicant Organization. Further, I understand and agree that written documentation will be substantially the work of human authorship and expressly acknowledge that the written documentation will not violate the intellectual property rights of ANCC and third parties. I understand and agree that any use of artificial intelligence programs, including but not limited to generative AI programs like Co-Pilot, ChapGPT, and Grammarly, will be limited to uses like proofreading or to providing minimal drafting assistance.
- I understand that providing false, misleading, or incomplete information is grounds for denial of the application, suspension, or revocation at any point during the review process or whenever this information is discovered.
- I have reviewed and understand the appeals process described in the PTAP Manual and incorporated herein by reference, that allows applicants for PTAP accreditation or reaccreditation the opportunity to appeal an adverse decision rendered as a result of a decision made by the COA-PTP.
- I understand and agree that any dispute arising in connection with the Applicant Organization's application or this attestation will be governed by Maryland law.

I certify that the information provided on and with this application is true, complete, and accurate.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Complete all sections and submit via email to [practicetransition@ana.org](mailto:practicetransition@ana.org).