**WNA CEAP**

**INTENT TO APPY OR REAPPLY AS AN APPROVED PROVIDER UNIT (APU)**

Please use this form to indicate your intent to apply or reapply as a provider of nursing continuing professional development through the Wisconsin Nurses Association. This will enable us to verify your eligibility.

To be eligible, your provider unit must:

|  |  |
| --- | --- |
| 1. | Have a clearly defined unit or department administratively and operationally responsible for nursing continuing professional development that has been established for at least 6 months. |
| 2. | Have a Primary Nurse Planner who is a registered nurse with an unrestricted nursing license and a baccalaureate degree or higher in nursing, and who has the authority to ensure compliance with accreditation criteria and WNA requirements in the provision of nursing continuing professional development. |
| 3. | Ensure Nurse Planner(s) who have unrestricted nursing licenses and a minimum of a baccalaureate degree in nursing and that each activity planned has a Nurse Planner as an active participant in the planning, implementation, and evaluation of each activity. |
| 4. | Target the majority (>50%) of the activities to registered nurses in a single HHs region and its contiguous states (based on the HHS region) Click here [www.hhs.gov/about/agencies/iea/regional-offices/index.html](http://www.hhs.gov/about/agencies/iea/regional-offices/index.html) for the HHS regions map for the identification of your region plus the states contiguous to your region.  Note: If your target audience is broader than those areas identified above, you are not eligible to apply to be an approved provider unit through WNA. You are, however, eligible to contact the ANCC Accreditation Program to apply for accreditation as a provider unit. |
| 5. | Be separate from any ineligible company that produces, markets, re-sells or distributes a product used on or by patients. |
| 6. | Follow all applicable federal, state, and local laws and regulations that affect the organization’s ability to meet criteria. |
| 7. | Disclose previous denials, suspensions, and/or revocations received from other ANCC accredited Approver Units. |

Complete and submit this form to the WNA Approver Unit via email to both [megan@wisconsinnurses.org](mailto:megan@wisconsinnurses.org) and [AAPD@wisconsinnurses.org](mailto:AAPD@wisconsinnurses.org).

* If you are **re-applying** as a provider unit, once you receive confirmation that you are eligible to apply as a provider unit, you may submit your provider application along with your three sample activities.
* For those applicants who are **first time applicants**, you will be contacted to discuss next steps.

**Section 1. DEMOGRAPHICS**

|  |  |
| --- | --- |
| **Date form completed:** |  |
| **Organization name:** |  |
| **Organization address:** |  |
| **Organization website:** |  |

|  |  |  |
| --- | --- | --- |
| **Are you currently approved as a provider unit through WNA?** |  | YES |
|  |  | NO |

|  |  |  |
| --- | --- | --- |
| **NEW APPLICANTS ONLY** | | |
| **Are you currently approved as a provider by another accredited approval body?** |  | YES |
|  |  | NO |
| **If yes, was the previous approval body operating under ANCC Primary Accreditation criteria?** |  | YES |
|  |  | NO |

|  |  |
| --- | --- |
| **Primary nurse planner name:** |  |
| *[The person who is responsible for the provider unit and with whom WNA will communicate.]* | |
| **Title of primary nurse planner:** |  |
| **Day phone number:** |  |
| **Email address:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| My organization is a: | | | | |
|  | Hospital | |  | Long term care facility |
|  | School/college of nursing | |  | Government agency |
|  | Professional association | |  | Continuing education company |
|  | Home health agency | |  | Health care office or practice |
|  | Business providing services to the healthcare industry | | | |
|  | Other (describe) |  | | |

**Section 2A. PROVIDER UNIT**

|  |  |
| --- | --- |
| My organization is a: | |
|  | A free-standing continuing education organization |
|  | Part of an organization that does other things besides continuing nursing education |

**Section 2B. PROVIDER TYPE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Check the box for your organization’s provider type: | | | | |
|  | **PROVIDER TYPE** | **TIER** | **REVIEW FEE** | *If needed, a description of each tier can be found* [*here*](https://www.wisconsinnurses.org/provider-fees/)*.* |
|  | Single Agency Provider | 1 | $1,750 |
|  | System Provider (2-5 facilities) | 2 | $1,900 |
|  | Large System Provider (6 or more facilities) | 3 | $2,100 |

**Section 3. NURSE PLANNERS**

Nurse Planners are (1) actively involved in planning all activities; (2) knowledgeable about education design process; and (3) have an unrestricted nursing license; and (4) a minimum of a baccalaureate degree **in** **nursing.**

|  |  |
| --- | --- |
| My organization is a: | |
|  | A free-standing continuing education organization |
|  | Part of an organization that does other things besides continuing nursing education |

|  |  |
| --- | --- |
| How many nurse planners are part of your provider unit? |  |

|  |
| --- |
| Please list names and credentials of all current nurse planners: |
|  |

**Section 4. REGIONAL TARGET MARKET**

|  |  |
| --- | --- |
| During the past year, was the target audience for more than 50% of your activities within your geographic range as noted above? | |
|  | Yes, proceed to Section 5. |
|  | No, you are not eligible to become or remain an Approved Provider. Please contact Megan ([megan@wiscconsinnurses.org](mailto:megan@wiscconsinnurses.org)) for a link to the ANCC Primary Accreditation Program to review the requirements for becoming an Accredited Provider. |

**Section 5. INELIGIBLE COMPANY**

|  |  |  |
| --- | --- | --- |
| A | Is your provider unit part of a company that produces, markets, re-sells, or distributes a product that is used on or by patients? | |
|  |  | YES |
|  |  | NO |

|  |  |  |
| --- | --- | --- |
| B | Is your provider unit’s organization owned or controlled by a company that produces, markets, re-sells, or distributes a product that is used on or by patients? | |
|  |  | YES |
|  |  | NO |

* If you answered **NO to both questions**, you have completed this form. Please send it via email to [megan@wisconsinnurses.org](mailto:megan@wisconsinnurses.org) and [AAPD@wisconsinnurses.org](mailto:AAPD@wisconsinnurses.org). You will be contacted to confirm your eligibility.
* If you answered **YES to either question**, you are not eligible to apply as a provider unit. Please contact Megan at [megan@wisconsinnurses.org](mailto:megan@wisconsinnurses.org).

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**FOR OFFICE USE ONLY**

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| **Eligible to apply as a first-time provider unit?** |  | YES |  |
|  |  | NO | If not, why not: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |