ANCC
AMERICAN NURSES CREDENTIALING CENTER
CERTIFICATION

Validation of Advanced Practice Nursing Education Form

CANDIDATE Please fill in section 1, and give this form to the Program Director of the program you completed, to fill in the balance of the form.

IMPORTANT NOTE For clinicians seeking the Adult-Gerontology or Pediatric Clinical Nurse Specialist certification examinations, and testing on or after April 17, 2014, the curriculum must include content across the health continuum from wellness through acute care, and must include content in health promotion and/or maintenance and differential diagnosis and disease management, including the use and prescription of pharmacologic and nonpharmacologic interventions.

PROGRAM DIRECTOR When entering course numbers, please include only the actual courses the Candidate completed, not the standard program courses.

Please fill in all required fields and either return a hard copy to the student or sign electronically and email to APRNValidation@ana.org.

Return this form by mail to:

American Nurses Credentialing Center
Attn: Certification Registration
P.O. Box 8785
Silver Spring, MD 20907-8785

Or sign electronically and email to: **APRNValidation@ana.org**

CANDIDATE INFORMATION

Applicant Last Name _____ First Name _____ MI _____

Other Legal Names Used _____

Address _____

City _____ State _____ Zip/Postal _____

Social Security Number (optional) _____ Email _____

PROGRAM INFORMATION

Name of University _____ City _____ State _____

Program Director Phone Number _____ Program Director Email _____

What type of program did the Candidate complete? ☐ Nurse Practitioner ☐ Clinical Nurse Specialist

What area of concentration? (e.g., family, adult-gero acute care): _____

The program this student completed has been accepted into ANCC's Certification Eligibility Curriculum Review Program. ☐ No ☐ Yes

Note: Participation in ANCC's Certification Eligibility Curriculum Review Program is not required to obtain certification. For more information about the program, please visit **http://www.nursecredentialing.org/CECRP.aspx.**

☐ Master's ☐ DNP ☐ Doctorate ☐ Post-Graduate Certificate[1] Indicate program completion date: _____

[1] If a post-graduate program was completed, you must attach a detailed description of the courses/clinical hours accepted from previous graduate program(s) and list all courses/clinical hours in the post-graduate certificate program that support eligibility. Place the information on letterhead and sign the document.

TOTAL Faculty Supervised Clinical Hours completed by the student: _____

Designate the organization which accredit(s) your program and include your accreditation expiration date:
☐ CCNE Expiration Date: _____ ☐ ACEN Expiration Date: _____

DUAL PROGRAMS

Did the Candidate complete a dual program? ☐ No ☐ Yes
(If yes, specify the role and population of the programs, and attach a detailed description of the content and clinical hours for each role and population. Use letterhead and sign the attachment.)

Role:	Role:
Population:	Population:
Clinical Hours:	Clinical Hours:

TOTAL Faculty Supervised Clinical Hours: _____

Candidate Name

COURSES

List the separate course numbers for the following courses: Please include ONLY courses that this Candidate completed in your program and, if applicable, courses accepted from another school. All courses must match the information on the Candidate's transcripts.

Advanced Physical or Health Assessment Course Course #:	**Appropriate Role Course(s) (i.e., NP, CNS)** Course #(s):	**For all Nurse Practitioners and candidates for Adult-Gerontology CNS and Pediatric CNS applicants testing on or after April 17, 2014: Appropriate Health Promotion/ Disease Prevention Course(s)[2]** Course #(s):
Advanced Pharmacology Course Course #:	**Appropriate Practicum Course(s)** Course #(s):	**For all Nurse Practitioners and candidates for Adult-Gerontology CNS and Pediatric CNS applicants testing on or after April 17, 2014: Appropriate Differential Diagnoses/ Disease Management Course(s)[2]** Course #(s):
Advanced Patho-physiology Course Course #:	**Appropriate Population-focused Course(s) (i.e., adult, family)** Course #(s):	**For NP and CNS Psychiatric/ Modalities/Mental Health Clinicians: List at least two Psycho-therapeutic Treatment Modalities/Courses** Course #(s):

[2] If the student completed an Adult Health CNS, Adult PMHCNS, or Child/Adolescent PMH CNS program, this section is not required.

STATEMENT OF UNDERSTANDING

I, _____ (insert name), _____ (insert title) of the _____ (insert program name), attest that the information provided in this Validation of Advanced Practice Nursing Education Form ("Form") is true, accurate, and complete and reflects only the coursework and clinical hours actually completed by the Candidate for Certification identified in Section 1, above (the "Candidate").

I further attest that I am duly authorized by _____ (insert name of college or university) to sign this Form.

(Forms received without a signature incur a delay in processing, which will cause a delay in the review of the Candidate's application and ability to take a certification examination.)

Required Program Director Signature | Print Name | Date