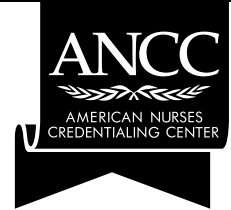


Contact Information Form



Section I. Organization Information

Name of Organization Providing the Nursing Skills Competency Program

Address

City

State

Zip/Postal

Country

Phone

Contact Person

Credentials

Address (if different from above)

City

State

Zip/Postal

Country

Phone

Fax

E-mail

Type of Organization (Check)

- | | |
|---|---|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Proprietary |
| <input type="checkbox"/> Long Term Care Facility | <input type="checkbox"/> Constituent Member Association |
| <input type="checkbox"/> Ambulatory Care Facility | <input type="checkbox"/> Governmental Nursing Division |
| <input type="checkbox"/> Specialty Nursing Organization | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> University/College | |

Section II. Program Information

Name of Nursing Skills Competency Program

Geographic Service Area (check all that apply)

- Local
- State
- Regional
- National
- International

ANCC ACCREDITED NURSING SKILLS COMPETENCY PROGRAM

Length of Existence of Program

New

Established (year) _____

Describe the Target Audience:

Is this program within the scope of practice for the target audience in the geographic area where it is being offered?

Yes

No

Goal*: Upon completion of this program, the learner will be qualified to:

* Goals must be worded in realistic, practice-based, measurable terms