**Individual Educational Activity Applicant Eligibility Verification**

**Section 1: Eligibility**

Applicants interested in submitting an individual educational activity for approval must complete the Eligibility Verification and meet all Eligibility Requirements. Verification forms received from applicants that do not meet Eligibility Requirements will be rejected without substantive review.

Click or tap here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Applicant

Click or tap here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: Describe - Click or tap here to enter text.

|  |
| --- |
| Click or tap here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Point of Contact: Name and Credentials  Click or tap here to enter text.  Primary Point of Contact: Title/Position  Click or tap here to enter text. Click or tap here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Point of Contact: Telephone Number Email Address |

* A currently licensed registered nurse with baccalaureate degree or higher in nursing is actively involved, in the planning, implementing and evaluation process of this continuing education activity and accountable for adherence to all ANCC Accreditation Program criteria.

Yes  No (If no, the applicant is not eligible to continue the application process)

**Please provide the name and credentials of the nurse responsible for this educational activity:**

|  |  |
| --- | --- |
| **Nurse Planner's Name** | **Credentials** |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Section 2: Commercial Interest**

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

* Blood banks,
* Constituent Member Associations,
* 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 applicants are not *automatically* exempt.** The ANCC Accreditation Program requires 501c applicants to be screened for eligibility.

**An “x” on this line identifies the applicant as exempt from ANCC’s definition of a commercial interest. Identify the applicant's exemption type from section 2 above and enter it here:** Click or tap here to enter text.

**If you checked the box above, then you have completed this application, proceed to Section 5.**

**Section 3 - Only complete this section if applicant organization is not exempt**

**An “x” on this line identifies the applicant as not exempt from the ANCC Accreditation Program’s definition of a commercial interest.** The following questions must be answered, so International Association of Forensic Nurses can assess the applicant's eligibility.

* Does the applicant produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients?

Yes **If yes**, the applicant is **not** eligible for approval of Individual Educational Activities.

No **If no**, complete the next bulleted question

* Is the applicant owned or controlled by a multi-focused organization (MFO\*) that produces, markets, resells, or distributes health care goods or services consumed by, or used on, patients?

Yes **If yes,** complete the next bulleted question

No **If no, this section of the application is complete, proceed to Section 5.**

* Is the applicant a separate and distinct entity from the MFO\*?

Yes - **If yes,** continue to section 4

No - **If no,** the applicant is **not** a separate and distinct entity from the MFO\* then the applicant is **not** eligible for approval of Individual Education Activities.

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

**Section 4: Commercial Interest Evaluation - Continued**

* Does the multi-focused organization that owns the applicant have a 501-C Non-profit Status?

Yes  No **If no**, complete the next bulleted question

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

Yes **If yes**, or not sure, please describe the relationship the company that the applicant has with a commercial interest and the types of work the company that owns the applicant does for or on behalf of a commercial interest that might be considered advocacy. Click or tap here to enter text.

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 **If yes**, 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. Click or tap here to enter text.

If yes, please complete and submit the **Individual Activity Eligibility Commercial Interest Addendum** with this Form.

No **If no, this section is complete, proceed to Section 5**.

**Section 5: Statement of Understanding**

On behalf of Click or tap here to enter text., I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature on behalf of Click or tap here to enter text., that Click or tap here to enter text.will comply with all eligibility requirements and approval criteria throughout the entire approval period, and that Click or tap here to enter text. will notify International Association of Forensic Nurses promptly if, for any reason while this application is pending or during any approval period, Click or tap here to enter text. does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for activity approval shall be sufficient cause for International Association of Forensic Nurses to deny, suspend or terminate Click or tap here to enter text.’s approval of this individual activity and to take other appropriate action against Click or tap here to enter text.

*(Eligibility Verification forms received without a signature incur a delay in processing which will cause a delay in the review of the individual education activity 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:** Click or tap here to enter text.

**Completed By: Name and Title:** Click or tap here to enter text.