Program Information Form

Entry-to-Practice Nurse Residency Programs

**General Information:**

Official Name of Institution:

Type of Institution (**select all that apply**)**:**

Academic medical center

Teaching hospital

Community hospital

Rural hospital

System with multiple hospitals that includes at least 1 academic medical center

System with multiple hospitals that does not include an academic medical center

Military hospital

VA hospital

Ambulatory care clinic

Long-term care facility

Primary care facility

Urgent care clinic

Community health center

Other (describe):

Number of Beds at Institution:

Partnering Academic Institution(s):

Type of nurse residency program pursuing accreditation **(select one):**

employee-based residency program  federally funded traineeship residency program  both

Website of institution/program:

**Program Leadership:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Full Name, Credentials, and Title | Street Address | City, State, Zip Code | Email | Phone and Fax |
| Chief Executive Officer |  |  |  |  |  |
| Chief Nursing Officer/Chief Nurse Executive |  |  |  |  |  |
| Residency Coordinator |  |  |  |  |  |

**Institutional Accreditation:**

|  |  |
| --- | --- |
| **Institutional Accreditor**  *(identify institutional accrediting agency name for both the healthcare organization and the partnering academic institution(s),*  *e.g., The Joint Commission, Higher Learning Commission)* | **Current Status**  *(e.g., full accreditation, provisional, warning, show cause)* |
|  |  |
|  |  |

If the current accreditation status of the institution is anything other than full accreditation, please provide to CCNE a copy of the institutional accrediting agency’s most recent accreditation action letter. Also provide (below) an explanation of the current status and how the entry-to-practice nurse residency program is impacted and/or implicated, if at all:

**Programmatic Accreditation:**

|  |  |
| --- | --- |
| **Programmatic Accreditor**  *(identify agency name for the partnering academic nursing program(s),*  *e.g., Commission on Collegiate Nursing Education)* | **Current Status**  *(e.g., full accreditation, provisional, warning, show cause)* |
|  |  |
|  |  |

If the current accreditation status of the partnering academic nursing program is anything other than full accreditation, please provide to CCNE a copy of the accrediting agency’s most recent accreditation action letter. Also provide (below) an explanation of the current status and how the entry-to-practice nurse residency program is impacted and/or implicated, if at all:

Entry-to-Practice Nurse Residency Program Information:

**Resident Data:**

|  |  |  |
| --- | --- | --- |
| Program Year | **# Residents Enrolled** | **# Completed Program** |
| Employee-based |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Federally funded traineeship |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Length of Program:**

Employee-based:

What year did the program begin?

What is the residency program length in months?

Federally funded traineeship:

What year did the program begin?

What is the residency program length in months?

**Additional Sites:**

Identify any additional sites where the nurse residency program is offered, the distance from the main location, and the average number of residents currently enrolled at each location.

|  |  |  |
| --- | --- | --- |
| **Site**  *(City, State)* | **Distance From Main Location**  *(in miles)* | **# Residents Enrolled** |
| Employee-based |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Federally funded traineeship |  |  |
|  |  |  |
|  |  |  |

**Check here** to verify that the Chief Nursing Officer/Chief Nurse Executive, identified above, has approved this completed form and confirms its contents as of      . (date)