**Mississippi Nurses Foundation**

**AA/IA-EV**

**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.

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

Name of Applicant

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

Street Address

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

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 -

|  |
| --- |
| Primary Point of Contact: Name and Credentials  Title/Position  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number E-mail 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/Licensure** |
|  |  |

**Section 2: Ineligible company**

**The following section is intended to collect information about the applicant organization’s corporate structure. Some organization types are automatically exempt from ANCC’s definition of an ineligible company including:**

* Blood banks,
* Constituent Member Associations,
* Diagnostic laboratories (hat do not sell proprietary products),
* 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,
* 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 an ineligible company. Identify the applicant's exemption type from section 2 above and enter it here:**      

If you checked the box above, then you have completed this questionnaire, 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 an ineligible company.** The following questions must be answered, so the Mississippi Nurses Foundation can assess the applicant's eligibility.

**NOTE:** Companies whose primary business is producing, marketing, re-selling, or distributing healthcare products used by or on patients are ineligible for ANCC accreditation per the Standards for Integrity and Independence in Accredited Continuing Education as an ineligible company

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

    Yes

     No

1. Does your organization advocate for an ineligible company?

    Yes

     No

1. Does your organization have a non-primary business function that includes producing, marketing, reselling, or distributing of healthcare products used by or on patients and/or advocating for, or on behalf of an ineligible company?

    Yes

     No

3A. If you answered YES to Q3, is the nonprimary business function, which led to answer yes, conducted by a separate legal entity with separate management and staff from the entity applying for accreditation?

     Yes

     No

3B. If you answered NO to Q3A, describe the organizational and procedural safeguards that are in place to ensure that the CME entity is separate from any ineligible company within the larger corporate structure of your organization.

     Yes

     No

3C. If you answered NO to Q3A, upload an organizational chart that includes the names of the persons in each position to depict these safeguards.

     Yes

     No

1. Does your organization have a parent company that:

**(A "parent company" is a separate legal entity that owns or fiscally controls an organization.)**

4A. produces, markets, re-sells, or distributes healthcare products used by or on patients, and/or

     Yes

     No

4B. advocates for, or on behalf of, an ineligible company?

     Yes

     No

1. Does your organization have a sister company that:

**(A "sister company" is a separate legal entity which is a subsidiary of the same parent company that owns or fiscally controls an organization.)**

5A. produces, markets, re-sells, or distributes healthcare products used by or on patients, and/or…

     Yes

     No

5B. advocates for, or on behalf of, ineligible companies?

     Yes

     No

1. If you answered YES to Q5, does your organization share management, employees, or governance structure with the sister company?

     Yes

     No

1. If you answered YES to Q5, are any owners, employees, or agents of the sister company involved in the planning, development, or implementation of educational content?

     Yes

     No

1. If you answered YES to Q5, does the sister company control or influence, in whole or in part, the operations of your organization?

     Yes

     No

**NOTE:** If you answered YES to Q3-8 your organization would likely be defined by the ACCME Standards for Integrity and Independence in Accredited Continuing Education as an ineligible company

**Section 5: Statement of Understanding**

On behalf of (insert name of applicant), 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 (insert name of applicant), that (insert name of applicant) will comply with all eligibility requirements and approval criteria throughout the entire approval period, and that (insert name of applicant) will notify the Mississippi Nurses Foundation promptly if, for any reason while this application is pending or during any approval period, (insert name of applicant) 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 the Mississippi Nurses Foundation to deny, suspend or terminate (insert name of applicant)’s approval of this individual activity and to take other appropriate action against (insert name of applicant).

*(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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Completed By: Name and Title**

Please return the completed Eligibility Verification Form and, if necessary, the Individual Activity Eligibility Commercial Interest Addendum with this Form to the Mississippi Nurses Foundation at: kdorr@msnurses.org