ANCC
AMERICAN NURSES CREDENTIALING CENTER
CERTIFICATION

Validation of APRN Education Form

CANDIDATE Please fill in the Candidate Information Section of this form and give it to the Program Director to complete the balance of the form and sign.

PROGRAM DIRECTOR When entering course numbers, please include the actual courses the Candidate completed. Please fill in all required fields and submit as follows:

- Hard copy, signed, and returned to the candidate to be forwarded to ANCC
- OR, signed electronically and e-mailed to **APRNValidation@ana.org**
- OR, mailed to:

  American Nurses Credentialing Center (ANCC)
  Attn: Certification Registration
  8515 Georgia Avenue, Suite 400
  Silver Spring, MD 20910

CANDIDATE INFORMATION

Applicant Last Name | First Name | MI

Other Legal Names Used | Email

Address | City | State | Zip/Postal

PROGRAM INFORMATION

Name of University | City | State

Program Director Name | Program Director Phone Number | Program Director Email

CANDIDATE EDUCATIONAL PREPARATION

Population and Role of Program Completed (e.g., Family Nurse Practitioner, Adult-Gerontology CNS)

Degree Type: ☐ Master's ☐ DNP ☐ Post-Master's Certificate* ☐ Post-Master's DNP*

***If a Post-Graduate program,** school must document and submit credit granted for prior courses/clinical hours accepted from previous program(s) via Gap Analysis and/or signed statement on school letterhead.

Date of (Anticipated) Completion | Number of Faculty-Supervised Direct, Patient Care Clinical Hours

Has the student completed all required APRN didactic courses/faculty supervised, direct patient care clinical hours, required for program completion? ☐ Yes ☐ No

Accreditation of Program Completed (at time of clinician's graduation): ☐ ACEN ☐ CCNE ☐ CNEA Exp Date: _____

Dual Program? ☐ Yes* ☐ No

***If yes,** specify the role and populations of the programs in the box above and attach a detailed description of the content and clinical hours for each role and population. Use letterhead and sign the attachment.

Content in:	Yes	No
Health Promotion/Disease Prevention Content		
Differential Diagnosis/Disease Management Content		

	Course Number	Title
Advanced Physical/Health Assessment		
Advanced Pathophysiology		
Advanced Pharmacology		
For PMHNP clinicians ONLY Content in at least 2 psychotherapeutic treatment modalities ☐Yes ☐No		

STATEMENT OF UNDERSTANDING • FOR FACULTY USE ONLY

I, _____ (insert name), _____ (insert title) of the _____ (insert program name), attest that I am duly authorized by the above school to confirm the information provided in this Validation of APRN Education Form ("Form") to be true, accurate, and complete, and reflect only the coursework and clinical hours actually completed by the Candidate for Certification identified above (the "Candidate").

(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

ANCC reserves the right to request a more detailed accounting of coursework/program completed. ANCC reserves the right to contact the faculty with questions upon review of transcript(s), etc.