AANP American Association of NURSE PRACTITIONERS®

AANP Accreditation Application Cover Sheet

A. Submitting Sponsor/Provider: _____

Choose Applicant Type: ◯ Tier 1: NPO Member ◯ Tier 2: 501c* ◯ Tier 3: Health Professions ◯ Tier 4: All Others

B. Co-Providing Sponsor** (if applicable): _____

Choose Applicant Type: ◯ Tier 1: NPO Member ◯ Tier 2: 501c* ◯ Tier 3: Health Professions ◯ Tier 4: All Others

*Include letter of non-profit status with application. **If applying with a co-provider, both the provider AND the co-provider must claim equal eligibility (e.g., both NPO members or both 501(c) statuses) for the discounted rate. If claiming different statuses, the highest fee scale applies.

C. Activity Title: _____

D. Initial Activity Date: _____ **Target Audience:** _____

Requested Contact Hours (CH)		Requested Pharmacology Hours (Rx)	
Overall contact hours for review		**Overall** Rx hours for review (if applicable)	
Maximum number of CHs **one person** can receive		Maximum number of Rx **one person** can receive	

E. In this submission, are there any AANP-Provided sessions (AANP CE Series)? ◯ No ◯ Yes; list title(s) below:

_____

F. Will this activity be presented more than twice? *(additional fees apply):* ◯ No ◯ Yes; select level below:

◯ Up to 10 Presentations ◯ Up to 15 Presentations ◯ Up to 25 Presentations

G. Expedited Review requested? *(additional fee applies; 10-14 business day review):* ◯ No ◯ Yes

H. Credit Breakdown requested? *(additional fee applies):* ◯ No ◯ Yes: ◯ By Session ◯ By Day ◯ Both

I. Activity Contact Name: _____

Address: _____ City/State: _____ Zip: _____

Organization Website: _____ Phone: _____

Name of person responsible for any fees: _____

Email address of person responsible for any fees: _____

J. Activity Type: ◯ Live Location: _____

◯ Enduring Host web address: _____

For Enduring Only: Specify how enduring material credit was determined (e.g., Mergener formula, pilot test, etc.):

_____

K. Need Determined By: ☐ Surveys ☐ Evaluations ☐ Literature Reviews ☐ New Technology ☐ Professional Organization Needs

L. Indicate any other accreditation for this activity: ☐ ACCME ☐ AAFP ☐ State Board of Nursing/ANCC

M. This activity is supported in whole or in part by a grant from: _____

This activity is pending support from: _____

N. I attest that I have reviewed and will abide by the current AANP Accreditation Policy and Process (v2019.1)

Initials: _____

The REVIEW fee (and expedite fee, if applicable) will be invoiced to the payor's email address listed above. DO NOT SEND PAYMENT until requested by AANP. Approval Fee (and all other fees) will be calculated and payment requested by AANP after final application review.