**American Association of Neuroscience Nurses**

**Individual Educational Activity Application**

**2015 Criteria**

1. **Applicants interested in submitting an individual educational activity for approval must complete (please check all boxes to confirm completion):**

**Individual Activity Applicant Eligibility Verification Form**

**Individual Activity Applicant Eligibility Commercial Interest Addendum (if applicable)**

**This form - Individual Educational Activity Application**

**Checking this box indicates that the Nurse Planner has read the Instructions and**

**Guidelines for submitting an Individual Activity for Approval and has submitted all attachments required. The application and all attachments must be received before payment applies.**

Is this continuing education? Is this learning activity intended to build upon the educational and experiential bases of the professional RN for the enhancement of practice, education, administration, research, or theory development, to improve the health of the public and RNs’ pursuit of their professional career goals?

Yes  No If **no**, the activity is **not** eligible for approval.

**Title of Activity:** Click here to enter text.

**Activity Location:** Click here to enter text.

**Date Form Completed:** Click here to enter a date.

**Activity Type (check below):**

Provider-directed, provider-paced: Live (in person, webinar, or series)

* Date of live activity: Click here to enter a date.
* Are you planning on offering this activity more than once?  Yes  No

Provider-directed, learner-paced: Enduring material

* Start date of enduring material: Click here to enter a date.
* Expiration/end date of enduring material: Click here to enter a date.
* Are you planning on offering this activity more than once?  Yes  No

Blended Activity

* Date(s) of enduring materials (e.g. prework): Click here to enter a date.
* Date of live portion of activity: Click here to enter a date.

**Number of contact hours requested:** Click here to enter text.

**Nurse Planner contact information for this activity:**

* Name and credentials: Click here to enter text.
* Email Address: Click here to enter text.

1. **Description of the professional practice gap (e.g. change in practice, problem in practice, opportunity for improvement):**

**Describe the current state:** Click here to enter text.

**Describe the desired state:** Click here to enter text.

**Identified gap:** Click here to enter text.

1. **Evidence to validate the professional practice gap (check all methods/types of data that apply):**

Survey data from stakeholders, target audience members, subject matter experts or similar

Input from stakeholders such as learners, managers, or subject matter experts

Evidence from quality studies and/or performance improvement activities to identify opportunities for improvement

Evaluation data from previous education activities

Trends in literature, law and health care

Direct observation

Other—Describe: Click here to enter text.

1. **Educational need that underlies the professional practice gap (select all that apply):**

Gap in Knowledge Gap in Skill Gap in Practice

1. **Description of the target audience (select all that apply):**

All RNs

Advanced Practice RNs

RNs in a Specialty Areas – Identify Specialty:

LPNs

Interprofessional – Describe: Click here to enter text.

Other – Describe: Click here to enter text.

1. **Desired learning outcome(s) *(What will the outcome be as a result of participation in this activity?):***
2. Click here to enter text.
3. Click here to enter text.
4. Click here to enter text.
5. Click here to enter text.
6. Click here to enter text.

**Area of impact (check all that apply):**

Nursing Professional Development Patient Outcome  Clinical Practice

Other- Describe: Click here to enter text.

1. **Outcome Measure(s) *(A quantitative statement as to how the outcome will be measured):***



1. **Content for this educational activity was chosen from:**

Information available from the following organization/web site: Click here to enter text.

Information available through peer-reviewed journal/resource: Click here to enter text.

Clinical guidelines: Click here to enter text.

Expert resource Click here to enter text.

Textbook reference: Click here to enter text.

Other: Click here to enter text.

Content referent information is available on the Educational Planning Table (Attachment 5)

1. **Learner engagement strategies**

Learner engagement strategies are listed on the Educational Planning Table provided

1. **Criteria for Awarding Contact Hours**

Criteria for awarding contact hours for live and enduring material activities include (Check all that apply):

Attendance for a specified period of time (e.g., 100% of activity, or miss no more than 10 minutes of activity)

Credit awarded commensurate with participation

Attendance at 1 or more sessions

Completion/submission of evaluation form

Successful completion of a post-test (e.g., attendee must score Enter Text % or higher)

Successful completion of a return demonstration

Other - Describe: Click here to enter text.

1. **Contact Hours Calculation:**

Provider-directed, provider-paced: Live (in person or webinar)

* Calculation: Click here to enter text.

Provider-directed, learner-paced: Enduring material

* Calculation: Click here to enter text.

Blended activity

* Calculation: Click here to enter text.

1. **Description of evaluation method: Evidence that change in knowledge, skills and/or practices of target audience was assessed (either short-term or long-term can be selected, or both can be):**

**Short-term evaluation options:**

Intent to change practice

Active participation in learning activity

Post-test

Return demonstration

Case study analysis

Role-play

Other – Describe: Click here to enter text.

**Long-term evaluation options:**

Self-reported change in practice

Change in quality outcome measure

Return on Investment (ROI)

Observation of performance

Other – Describe: Click here to enter text.

1. **Commercial Interest Verification**

This activity has **no** commercial support or sponsorship

This activity has commercial support and/sponsorship

|  |  |  |
| --- | --- | --- |
| **Name of Commercial Support Organization** | **Type of Commercial Support (Financial or In-Kind)** | **Amount of Commercial Support** |
| *Example: Astellas* | *Financial* | *$5,000* |
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1. **Joint Provider Verification**

This activity will **not** be joint-provided

This activity will be joint provider with - Click here to enter text.

**ATTACHMENTS**

**Please provide evidence of the following:**

|  |  |
| --- | --- |
| **Attachment 1** | Eligibility Verification Form |
| **Attachment 2** | Names and credentials of all individuals in a position to control content (must identify the individuals who fill the roles of Nurse Planner and content expert(s)). |
| **Attachment 3** | Qualifications documentation for the Nurse Planner and content expert. **(all other qualifications documentation should be stored with the Nurse Planner but does not need to be submitted to AANN).** |
| **Attachment 4** | Conflict of interest documentation from all individuals in a position to control content – The Nurse Planner and Content Experts **(all other conflict of interest documentation should be stored with the Nurse Planner but does not need to be submitted to AANN).** |
| **Attachment 5** | Educational Planning Table |
| **Attachment 6** | Activity Agenda/Marketing Materials |
| **Attachment 7** | Documentation of completion and/or certificate. |
| **Attachment 8** | Commercial Support Agreement with signature and date (if applicable) |
| **Attachment 9** | Evidence of required information provided to learners prior to start of the educational activity:  Approval statement of provider awarding contact hours  Criteria for awarding contact hours  Presence or absence of conflicts of interest for all individuals in a position to control content  Planning Committee, presenters, faculty, authors, and content reviewers)  Commercial support (if applicable)  Expiration date (enduring materials only)  Joint Providership (if applicable) |
| **Attachment 10** | Evaluation Form |
| **Attachment 11** | Summative evaluation (must submit after activity date) |

**Nurse Planner Name and Credentials:** Click here to enter text.

**Date:** Click here to enter text.

**Attachment 1**

**Eligibility Verification Form**

1. **Eligibility**

**Name of Applicant:** Click here to enter text.

**Street Address:** Click here to enter text.

**City:** Click here to enter text.

**State:** Click here to enter text. **Zip/Country:** Click here to enter text.

**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 here to enter text.

**Primary Point of Contact (Nurse Planner’s Name and Credentials):** Click here to enter text.

Title/Position: Click here to enter text.

Telephone Number: Click here to enter text.

Email Address: Click here to enter text.

**Secondary Point of Contact if applicable (administrator):** Click here to enter text.

Title/Position: Click here to enter text.

Telephone Number: Click here to enter text.

Email Address: Click here to enter text.

* Has the applicant ever been denied **accreditation by ANCC** or had its accreditation status suspended or revoked?  Yes  No
* If yes, please provide the following information:
* Date: Click here to enter text.

Action:  Denial  Suspension  Revocation

* Brief description: Click here to enter text.
* Has the applicant ever been denied **approval** by or had approval suspended or revoked for an individual activity or a provider application by AANN?  Yes  No

If yes, please provide the following information:

Date: Click here to enter text.

Action:  Denial  Suspension  Revocation

Brief description: Click here to enter text.

* Has the applicant ever been denied **approval** by or had approval suspended or revoked for an individual activity or a provider application by another ANCC Accredited Approver?  Yes  No

**If yes**, please provide the following information:

Date: Click here to enter text.

Action:  Denial  Suspension  Revocation

Brief description: Click here to enter text.

1. **Commercial Interest**

**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 page 13 below:** Click here to enter text.

*If the applicant checks the above box, proceed to C.*

**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 AANN 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, re-sells, 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 questionnaire is complete, proceed.**

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

Yes - **If yes,** continue

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.

* 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 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?

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.

No **If no, this section of the questionnaire is complete**.

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

1. 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 **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 **AANN** 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 **AANN** 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):** Click here to enter text.

**Date:** Click here to enter text.

**Primary Point of Contact (Nurse Planner’s Name and Credentials):** Click here to enter text.

**Attachment 2**

**Individuals in a Position to Control Content**

Complete the table below for each person in a position to control content of the educational activity and include name, credentials, educational degree(s), role on the planning committee, and expertise that substantiates their role. There must be one Nurse Planner and one other planner to plan each educational activity. The Nurse Planner is knowledgeable of the CNE process and is responsible for adherence to the ANCC criteria. One planner needs to have appropriate subject matter expertise for the educational activity being offered (Content Expert). **The individuals who fill the roles of Nurse Planner and Content Expert must be identified.**

*Names and credentials of all individuals in a position to control content (must identify the individuals who fill the roles of Nurse Planner and content expert(s)).*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of individual and credentials** | **Individual’s role in activity** | **Planning committee member? (Yes/No)** | **Name of commercial interest** | **Nature of relationship** |
| *Example: Jane Smith, RN-BC* | *Nurse Planner* | *Yes* | *None* | *---* |
| *Example: Sue Brown, RNC* | *Content Expert* | *Yes* | *None* | *---* |
| *Example: John Doe, PhD* | *Presenter* | *No* | *Pfizer* | *Speakers Bureau* |
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Completion of the line below serves as the electronic signature that the Nurse Planner has reviewed and resolved all actual or potential conflicts of interest. **It also certifies that conflict of interests and content expertise for all individual is stored with nurse planner.**

Click here to enter text. **Electronic Signature (Required)** Click here to enter text.  **Date**

**Primary Point of Contact (Nurse Planner’s Name and Credentials):** Click here to enter text.

**Attachment 3**

**Qualification Documentation for the Nurse Planner and Content Expert**

**(for multiple content experts, copy and paste info and submit)**

**Nurse Planner:**

**Demographic Data**

Name with Credentials/Degrees: Click here to enter text.

Nursing Degree(s):  BSN  Masters  Doctorate

**Expertise**

Please describe expertise and years of training specific to this educational activity **and** describe knowledge and/or experience with the CNE process and adherence to ANCC criteria.



**Content Expert 1:**

**Demographic Data**

Name with Credentials/Degrees: Click here to enter text.

If RN, Nursing Degree(s):  Associate  BSN  Masters  Doctorate

**Expertise**

Please describe expertise and years of training specific to this educational activity.



**Content Expert 2 (if applicable):**

**Demographic Data**

Name with Credentials/Degrees: Click here to enter text.

If RN, Nursing Degree(s):  Associate  BSN  Masters  Doctorate

**Expertise**

Please describe expertise and years of training specific to this educational activity.



**The following information must be stored with the Nurse Planner but does not need to be submitted to AANN. AANN may ask for this information at a later date if necessary.**

**Faculty/Presenter/Author 1:**

**Demographic Data**

Name with Credentials/Degrees: Click here to enter text.

If RN, Nursing Degree(s):  Associate  BSN  Masters  Doctorate

**Expertise**

Please describe expertise and years of training specific to this educational activity.



**Faculty/Presenter/Author 2 (if applicable):**

**Demographic Data**

Name with Credentials/Degrees: Click here to enter text.

If RN, Nursing Degree(s):  Associate  BSN  Masters  Doctorate

**Expertise**

Please describe expertise and years of training specific to this educational activity.



**Faculty/Presenter/Author 3 (if applicable):**

**Demographic Data**

Name with Credentials/Degrees: Click here to enter text.

If RN, Nursing Degree(s):  Associate  BSN  Masters  Doctorate

**Expertise**

Please describe expertise and years of training specific to this educational activity.



**Attachment 4**

**Conflict of Interest Documentation**

**(copy attachment 4 and place after for multiple forms)**

**American Association of Neuroscience Nurses**

**Conflict of Interest Form**

**2015 Criteria**

Role in Educational Activity: (Check all that apply) Nurse Planner

Content Expert

Faculty/Presenter/Author

**Section 1: Demographic Data**

Name with Credentials/Degrees: Click here to enter text.

If RN, Nursing Degree(s):  AD  Diploma  BSN  Masters  Doctorate

Address: Click here to enter text.

Phone Number: Click here to enter text. Email Address: Click here to enter text.

Current Employer and Position/Title: Click here to enter text.

**Section 2: Conflict of Interest**

The potential for conflicts of interest exists when an individual has the ability to control or influence the content of an educational activity **and** has a financial relationship with a *commercial interest*\*, the products or services of which are pertinent to the content of the educational activity. The Nurse Planner is responsible for evaluating the presence or absence of conflicts of interest and resolving any identified actual or potential conflicts of interest during the planning and implementation phases of an educational activity. If the Nurse Planner has an actual or potential conflict of interest, he or she should recuse himself or herself from the role as Nurse Planner for the educational activity.

**\**Commercial interest***, as defined by ANCC, is any entity producing, marketing, reselling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets, resells, or distributes healthcare goods or services consumed by or used on patients.

Commercial Interest Organizations are ***ineligible*** for accreditation.

An organization is NOT a Commercial Interest Organization\* if it is:

* A government entity;
* A non-profit (503(c)) organization;
* A provider of clinical services directly to patients, including but not limited to hospitals, health care agencies and independent health care practitioners;
* An entity the sole purpose of which is to improve or support the delivery of health care to patients, including but not limited to providers or developers of electronic health information systems, database systems, and quality improvement systems;
* A non-healthcare related entity whose primary mission is not producing, marketing or selling or distributing health care goods or services consumed by or used on patients.
* Liability insurance providers
* Health insurance providers
* Group medical practices
* Acute care hospitals (for profit and not for profit)
* Rehabilitation centers (for profit and not for profit)
* Nursing homes (for profit and not for profit)
* Blood banks
* Diagnostic laboratories

(\*Reference: Accreditation Council for Continuing Medical Education (ACCME) Standards of Commercial Support, August 2007 (www.accme.org) - ANCC’s definition is intended to ensure compliance with Food and Drug Administration Guidance on Industry-Supported Scientific and Educational Activities and consistency with the ACCME definition)

All individuals who have the ability to control or influence the content of an educational activity must disclose all ***relevant relationships\*\**** with any commercial interest, including but not limited to members of the Planning Committee, speakers, presenters, authors, and/or content reviewers. Relevant relationships must be disclosed to the learners during the time when the relationship is in effect and for 12 months afterward. All information disclosed must be shared with the participants/learners prior to the start of the educational activity.

**\*\**Relevant relationships****,* as defined by ANCC, are relationships with a commercial interest if the products or services of the commercial interest are related to the content of the educational activity.

* Relationships with any commercial interest of the individual’s spouse/partner may be relevant relationships and must be reported, evaluated, and resolved.
* Evidence of a relevant relationship with a commercial interest may include but is not limited to receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (stock and stock options, excluding diversified mutual funds), grants, contracts, or other financial benefit directly or indirectly from the commercial interest.
* Financial benefits may be associated with employment, management positions, independent contractor relationships, other contractual relationships, consulting, speaking, teaching, membership on an advisory committee or review panel, board membership, and other activities from which remuneration is received or expected from the commercial interest.

Is there an actual, potential or perceived conflict of interest for yourself or spouse/partner?

Yes  No

**If yes,** complete the table below for all actual, potential or perceived conflicts of interest\*\*:

|  |  |  |
| --- | --- | --- |
| Check all that apply | Category | Description |
|  | Salary |  |
|  | Royalty |  |
|  | Stock |  |
|  | Speakers Bureau |  |
|  | Consultant |  |
|  | Other |  |

\*\* All conflicts of interest, including potential ones, must be resolved prior to the planning, implementation, or evaluation of the continuing nursing education activity.

**Section 3: Statement of Understanding**

Completion of the line below serves as the electronic signature of the individual completing this Biographical/Conflict of Interest Form and attests to the accuracy of the information given above.

Click here to enter text.Click here to enter text.

**Typed or Electronic Signature: Name and Credentials (Required) Date**

**Section 4: Conflict Resolution (to be completed by Nurse Planner)**

1. Procedures used to resolve conflict of interest or potential bias if applicable for this activity:

(Check all that apply)

Not applicable since no conflict of interest.

Removed individual with conflict of interest from participating in all parts of the educational activity.

Revised the role of the individual with conflict of interest so that the relationship is no longer relevant to the educational activity.

Not awarding contact hours for a portion or all of the educational activity.

Undertaking review of the educational activity by a content reviewer to evaluate for potential bias, balance in presentation, evidence-based content or other indicators of integrity, and absence of bias, AND monitoring the educational activity to evaluate for commercial bias in the presentation.

Undertaking review of the educational activity by a content reviewer to evaluate for potential bias, balance in presentation, evidence-based content or other indicators of integrity, and absence of bias, AND reviewing participant feedback to evaluate for commercial bias in the activity.

Other - Describe: Click here to enter text.

**Nurse Planner Signature (\* If form is for the activity Nurse Planner, an individual other than the Nurse Planner must review and sign the form).**

Completion of the line below serves as the electronic signature of the Nurse Planner reviewing and resolving the content of this Conflict of Interest Form**. It also certifies that conflict of interest and content expertise for this individual is stored with nurse planner.**

Click here to enter text.Click here to enter text.

**Typed or Electronic Signature: Name and Credentials (Required) Date**

**Attachment 5**

**Educational Planning Table**

**Title of Activity:** Click here to enter text.

The following must match what is written in Section B of the application:

**Description of current state:** Click here to enter text.

**Description of desired state:** Click here to enter text.

**Identified gaps:** Click here to enter text.

**Areas of Impact:**

**(Select all that apply)**

Nursing Professional Development

Patient Outcome

Clinical Practice

Other – Please Describe Click here to enter text.

**Learning Outcomes (must be measureable):**

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.
4. Click here to enter text.
5. Click here to enter text.

| **CONTENT**  **(Topics)** | **TIME**  **FRAME (if live)** | **PRESENTER/ AUTHOR** | **TEACHING METHODS/LEARNER ENGAGEMENT STRATEGIES** |
| --- | --- | --- | --- |
| Provide an outline of the content | Approx. time required | List the Presenter/Author | List the learner engagement strategies to be used by Faculty, Presenters, Authors |
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| **List the evidence-based references used for developing this educational activity:** | | | |

**Attachment 6**

**Activity Agenda/Marketing Materials**

**Attachment 7**

**Documentation of Completion or Certificate**

**Attachment 8**

**Commercial Support Agreement**

**American Association of Neuroscience Nurses**

**Individual Activity Applicant**

**Eligibility Commercial Interest Addendum**

|  |  |
| --- | --- |
| **Applicants should only complete this addendum if directed to do so by the Individual Educational Activity Applicant Eligibility Verification or by the Accredited Approver.**  Name of Applicant: Click here to enter text.   |  | | --- | | Click here to enter text.  Primary Point of Contact: Name and Credentials  Click here to enter text.  Title/Position  Click here to enter text. Click here to enter text.  Telephone Number E-mail Address | |

**Please answer the following questions to assist in verifying the applicant's eligibility.**

* Are there organizational and procedural safeguards (‘corporate firewalls’) in place to ensure that the applicant is separate from any commercial interest listed on the Individual Educational Activity Applicant Eligibility Form?

Yes

No **If no**, the applicant is **not** eligible for approval of individual education activities

**If yes**, complete the following:

1. Are the applicant’s offices physically separate from the MFO or component of the MFO?

Yes  No

1. Is the applicant a separate legal entity from the MFO and components of the MFO?

Yes  No

1. Does the applicant have a separate federal tax identification number from the MFO and components of the MFO?

☐Yes ☐ No

1. Do any members of the MFO or component of the MFO have the ability to do any of the following:

* Require or suggest information relating to the content of the applicant's CE activities;

Yes       No

* Review of activity content;

Yes       No

* Suggest faculty for an activity;

Yes       No

* Recommend either educational format or methods of evaluation.

Yes       No

1. Does the applicant ‘share’ services with the MFO or component of the MFO?

Yes No

**If yes**, please list services that are ‘shared’ and describe how this is accomplished.

Click here to enter text.

1. Please describe any additional information that ensures the applicant is independent of a commercial interest’s ownership and control. Click here to enter text.
2. Are the applicant’s servers, phone and fax lines, email addresses, web domains, if any, and other information technology infrastructures separated in any way from the MFO or component of the MFO?

Yes  No

1. Can employees of the MFO or component of the MFO access electronic information concerning the applicant's CE activities stored on the applicant’s computers?

Yes  No

If yes, please explain: Click here to enter text.

1. In connection with the applicant’s finances, which of the following does the applicant do?

Maintain own budget

Yes  No

Conduct own grant reconciliation

Yes  No N/A

Maintain own Profit/Loss statement(s)

Yes  No

Maintain own billing, accounts receivable and payable

Yes  No

Issue own W-9 forms.

Yes  No

1. Is the applicant the employer of record for its own employees?

Yes  No

1. Does the applicant have any written policies addressing its independence in the manner in which its CE activities are planned and published?

Yes  No

1. Does the applicant collaborate on any projects with companies that meet the ANCC Accreditation Program’s definition of a commercial interest?

Yes  No

1. Please describe anything else that assures independence of the applicant in connection with its governance structure. Click here to enter text.

Please provide a diagram showing the applicant in relation to the MFO and/or component of the MFO, as applicable. Please indicate which component of the MFO meets the definition of a commercial interest.

If there are any written policies regarding assuring the independence of the applicant from the MFO or component of the MFO, please provide copies for **American Association of Neuroscience Nurses**.

**Statement of Understanding:**

Writing a name in the box below serves as the electronic signature of the individual completing this Individual Activity Applicant Eligibility Commercial Interest Addendum and attests to the accuracy of the information given above.

Click here to enter text.Click here to enter text.

**Nurse Planner Electronic Signature: Name and Credentials (Required) Date**

**Attachment 9**

**Disclosure Evidence**

**Attachment 10**

**Evaluation Form**