The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619



MAURA T. HEALEY

Governor

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Lieutenant Governor

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Secretary

ROBERT GOLDSTEIN, MD, PhD Commissioner

**Tel: 617-624-6000**

**www.mass.gov/dph**

**244 CMR 6.05 Massachusetts Board of Nursing Petition for Nursing Education Programs offered by a parent institution that has a principle place of business outside of Massachusetts offering Clinical Experience in Massachusetts**

**Part A – Program Information**

**Part A:** Submit one time **6 months** **prior** to the start of any clinical experiences. Any changes to the Program information provided on this form must be updated **within** **7 days** of such change.

**Part B:** Submit **30 days prior** to any student clinical placement.

**Parent Institution Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**CEO Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**CEO Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CEO Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Administrator Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Administrator Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Administrator Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nursing Education Program Delivery Method:**

**🞎** Face to face **🞎**Hybrid/Blended **🞎** Fully Online

**Program Type:**

**🞎** LPN

**🞎**ADN

**🞎**RN Diploma

**🞎**BSN

**🞎**Direct Entry Masters

**Program Approval Status and Approving Authority:**

**🞎 State Board of Nursing State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**🞎Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approval Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Letter or document must be attached.

**Parent Institution Accreditation:**

**Accreditation Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Accreditation Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Letter or document must be attached.

**Nursing Program Accreditation (Must be a Board approved accreditation agency):**

**Accreditation Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Accreditation Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Letter or document must be attached

🞎**No Program Accreditation**

**Authorization to Operate in MA by:**

**🞎 Participating Member of SARA**

**🞎Office of Private Occupational School Education**

Letter or document must be attached

**As CEO, I certify under the pains and penalties of perjury, that the information provided in this application is accurate.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** |  | **First Name** | **Title** |
|  |  |  | \_ |

**Signed:** **Date:**

**As Program Administrator, I certify under the pains and penalties of perjury, that the information provided in this application is accurate.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** |  | **First Name** | **Title** |
|  |  |  | \_ |

**Signed:** **Date:** \_\_\_