244 CMR 6.07(1) Program Changes: Increased Admissions

An increase in student admissions of 20% or more above the most recent three-year admission mean

Massachusetts Board of Registration in Nursing (Board) regulation 244 CMR 6.07(1) requires the program administrator of a Board-approved nursing education program to notify the Board of Nursing of a planned increase in student admissions of 20% or more above the most recent three-year admission mean.

**Section A.**

### Please complete ALL sections.

## Parent Institution Information

|  |  |
| --- | --- |
| Date: |  |
| Parent Institution: |  |
| Address: |  |
| City, State, Zip: |  |
| Chief Executive Officer Name and Credentials: |  |
| Email: |  |

**Parent Institution Accreditation Status**

|  |  |
| --- | --- |
| Agency: |  |
| Last Review: |  |
| Outcome: |  |
| Next Review: |  |

## Nursing Education Program Information

|  |  |
| --- | --- |
| Nursing Education Program: |  |
| Address: |  |
| City, State, Zip: |  |
| Nurse Administrator Name and Credentials: |  |
| Email: |  |
| Nursing Program Type: | Practical  Associate degree  Diploma  Baccalaureate  Direct Entry Masters |

**Nursing Program Accreditation Status**

|  |  |
| --- | --- |
| Nursing Accreditation Agency: |  |
| Last Review  (Accreditation Cycle and Year): |  |
| Outcome: | Initial Accreditation  Not Accredited  Continuing Accreditation |
| Continuing Accreditation with Conditions  Follow-Up Report due: \_\_\_\_\_\_\_\_\_\_\_ |
| Continuing Accreditation with Warning  Follow-Up Report/Follow-Up Visit due: \_\_\_\_\_\_\_\_\_\_\_ |
| Continuing Accreditation for Good Cause  Follow-Up Report/Follow-Up Visit due: \_\_\_\_\_\_\_\_\_\_\_ |
| Next Review  (Accreditation Cycle and Year): |  |

## Nursing Program Options

|  |  |
| --- | --- |
| Program Option Name: |  |
| Location Name: |  |
| Delivery Method: | Face-to-Face  Hybrid  Distance Education |
| Percentage of Nursing Credits Delivered by Distance Education: | 0%  1–24%  25–49%  50–100% |
| Current Student Enrollment |  |

|  |  |
| --- | --- |
| Program Option Name: |  |
| Location Name: |  |
| Delivery Method: | Face-to-Face  Hybrid  Distance Education |
| Percentage of Nursing Credits Delivered by Distance Education: | 0%  1–24%  25–49%  50–100% |
| Current Student Enrollment |  |

|  |  |
| --- | --- |
| Program Option Name: |  |
| Location Name: |  |
| Delivery Method: | Face-to-Face  Hybrid  Distance Education |
| Percentage of Nursing Credits Delivered by Distance Education: | 0%  1–24%  25–49%  50–100% |
| Current Student Enrollment |  |

## Current Total Nursing Program Student Enrollment (all program options/cohorts/locations combined)

|  |  |
| --- | --- |
| Current Student Enrollment: |  |

## Current Total Number of Faculty

|  |  |
| --- | --- |
| Full-time: |  |
| Part-time: |  |

# Section B.

What is the anticipated admission number for the upcoming Academic year?

Narrative:

What are the admission numbers reported for the most recent three years?

Narrative:

What is the percentage of increase in admissions from last year’s annual report to the Board?

Narrative:

## Provide a brief description of rationale for the increased admission.

Narrative:

What was the total number of student enrollment (all students in each cohort/program option/location) for the previous academic year?

Narrative:

Describe any change in the number and qualifications of full- and part-time faculty teaching in the program that were needed with the increase in admissions (244 CMR 6.04(2)(b).

Narrative:

Maximum student-faculty ratio in didactic and lab setting (244 CMR 6.04(5)(a).

Narrative:

Describe the role of support staff within the nursing education unit and any changes that were needed with the increase (244 CMR 6.04(5)(a).

Narrative:

Describe any changes in the availability of or need for additional clinical learning sites following the increase in admissions (244 CMR 6.04(5)(b).

Narrative:

Maximum student-faculty ratio in clinical practice (244 CMR 6.04(5)(c).

Narrative:

Describe any changes in the availability the learning resources accessible to faculty and students related to the change in admissions. (244 CMR 6.04(5)(d).

Narrative:

Describe any changes of physical resources following the increase in admissions (244 CMR 6.04(5)(e).

Narrative:

Describe any changes of fiscal resources following the increase in admissions (244 CMR 6.04(5)(f).

Narrative:

### Provide, if applicable, any additional information of how the change in the nursing program affects the program’s compliance with regulations at 244 CMR 6.04.

Narrative:

# Section C. Outcomes

### Please complete ALL of the following sections for the three (3) most recent years. For expected levels of achievement (ELAs), include a timeline (e.g., 70% of students will complete the program in 150% of the program length).

|  |  |  |
| --- | --- | --- |
| **First-time Performance on Licensure/Certification Examination**  **Aggregated for Entire Program** | | |
| Expected Level of  Achievement | Year | Licensure Examination Pass Rate |
|  | 20\_\_ | % |
|  | 20\_\_ | % |
| Same as above |
|  | 20\_\_ | % |
| Same as above |

|  |  |  |
| --- | --- | --- |
| **Performance on Program Completion – Aggregated for Entire Program** | | |
| Expected Level of  Achievement | Year | Program Completion Rate |
|  | 20\_\_ | % |
|  | 20\_\_ | % |
| Same as above |
|  | 20\_\_ | % |
| Same as above |

|  |  |  |
| --- | --- | --- |
| **Performance on Job Placement – Aggregated for Entire Program** | | |
| Expected Level of  Achievement | Year | Program Completion Rate |
|  | 20\_\_ | % |
|  | 20\_\_ | % |
| Same as above |
|  | 20\_\_ | % |
| Same as above |

|  |  |  |
| --- | --- | --- |
| **Admission Rates Reported on Annual Reports – Aggregated for Entire Program** | | |
| Expected Level of  Achievement | Year | Number of Admissions |
|  | 20\_\_ | % |
|  | 20\_\_ | % |
| Same as above |
|  | 20\_\_ | % |
| Same as above |

**Section D. Required Documentation**

(to be included as an Appendix)

Faculty Profile Table (attached)

List of additional clinical learning sites

☐ Documentation of final approval from the governing organization/institution (if applicable)

☐ Documentation of final approval, acceptance, or notification of the substantive change from the Program accrediting agency (if applicable)

☐ Documentation of institutional accreditor approval for distance education (if applicable)

|  |  |
| --- | --- |
| Signature: |  |
| Date |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Full-time Faculty Profile Table** | | | | | | |
| **Last Name** | **First Name** | **MA RN License** | **Dates of Employment** | **Academic Degrees, Years**  **(List all degrees)** | **Assigned Nursing Courses (didactic, lab, or clinical)** | **Waivered faculty? If yes, which option?** |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Part-time Faculty Profile Table** | | | | | | |
| **Last Name** | **First Name** | **MA RN License** | **Dates of Employment** | **Academic Degrees, Years**  **(List all degrees)** | **Assigned Nursing Courses (didactic, lab, or clinical)** | **Waivered faculty? If yes, which option?** |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |
| Click here to enter text. | Click here to enter text. | RN  Date of Expiration | Date of Hire  End Date if applicable | Click here to enter text. | Click here to enter text. | Yes  Waiver option  No |