American Society of PeriAnesthesia Nurses
Individual Activity Applicant Eligibility Verification

Section 1: Demographic Data

Applicants interested in submitting an individual educational activity for approval must complete the Eligibility Verification and meet all Eligibility Requirements. Verification forms received from applicants that do not meet Eligibility Requirements will be rejected without substantive review.

_____

Name of Organization

_____

Street Address

_____

City State Zip/Postal Country

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

_____

Primary Point of Contact: Name and Credentials

_____

Title/Position

_____

Telephone Number E-mail Address

APM-FRM-093, Accredited Approver Individual Activity Applicant Eligibility Verification, Version 3.0, 11.24.2025

A currently unrestricted licensed registered nurse (or international equivalent) with a baccalaureate degree (or international equivalent) or higher in nursing is actively involved in the planning, implementing, and evaluation process of this continuing education activity and accountable for adherence to all ANCC Accreditation Program criteria.

☐Yes ☐No (If no, the applicant is not eligible to continue the application process)

Please provide the name and credentials of the nurse responsible for this educational activity:

Nurse Planner Name	Credentials

Section 2: Ineligible Company

The following section is intended to collect information about the applicant organization's corporate structure. NOTE: Companies that are ineligible to be approved (ineligible companies) are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. Certain organizational types are automatically eligible and exempt from the definition of an ineligible company, as per the Standards for Integrity and Independence in Accredited Continuing Education.

Is your organization one of the following? Check the box applicable:

☐ Ambulatory procedure centers
☐ Blood banks
☐ Diagnostic labs that do not sell proprietary products
☐ Electronic health record company
☐ Government or military agency
☐ Group medical practice
☐ Health law firms
☐ Health profession membership organization
☐ Hospital or healthcare delivery system
☐ Infusion center
☐ Insurance or managed care company
☐ Nursing home
☐ Pharmacy that does NOT manufacture proprietary compounds
☐ Publishing or education company
☐ Rehabilitation center
☐ School of medicine/nursing or health science university
☐ Software or game developer

If you checked a box above, then you have completed this questionnaire and should proceed to Section 4.

APM-FRM-093, Accredited Approver Individual Activity Applicant Eligibility Verification, Version 3.0, 11.24.2025

Section 3: Only complete this section if application organization is not exempt

_____ **An "X" on this line identifies the applicant organization as <u>not</u> exempt from the Standards for Integrity and Independence in Accredited Continuing Education definition of an ineligible company.** The following questions must be answered, so the American Society of PeriAnesthesia Nurses can assess the applicant organization's eligibility.

NOTE: Companies whose primary business is producing, marketing, re-selling, or distributing healthcare products used by or on patients are ineligible for approval per the Standards for Integrity and Independence in Accredited Continuing Education as an ineligible company.

1. Does your organization, or a part of your organization, produce, market, re-sell, or distribute healthcare products used by or on patients?

   _____ Yes
   _____ No

2. Does your organization advocate for an ineligible company?

   _____ Yes
   _____ No

3. Does your organization have a non-primary business function that includes producing, marketing, reselling, or distributing of healthcare products used by or on patients and/or advocating for, or on behalf of an ineligible company?

   _____ Yes
   _____ No

   3A. If you answered YES to Q3, is the nonprimary business function, which led to answer yes, conducted by a separate legal entity with separate management and staff from the entity applying for accreditation?

   _____ Yes
   _____ No

   3B. If you answered NO to Q3A, describe the organizational and procedural safeguards that are in place to ensure that the CME entity is separate from any ineligible company within the larger corporate structure of your organization.

   _____ Yes
   _____ No

APM-FRM-093, Accredited Approver Individual Activity Applicant Eligibility Verification, Version 3.0, 11.24.2025

3C. If you answered NO to Q3A, upload an organizational chart that includes the names of the persons in each position to depict these safeguards.

____ Yes
____ No

4. Does your organization have a parent company that:

(A "parent company" is a separate legal entity that owns or fiscally controls an organization.)

4A. produces, markets, re-sells, or distributes healthcare products used by or on patients, and/or

____ Yes
____ No

4B. advocates for, or on behalf of, an ineligible company?

____ Yes
____ No

5. Does your organization have a sister company that:

(A "sister company" is a separate legal entity which is a subsidiary of the same parent company that owns or fiscally controls an organization.)

5A. produces, markets, re-sells, or distributes healthcare products used by or on patients, and/or…
____ Yes
____ No

5B. advocates for, or on behalf of, ineligible companies?
____ Yes
____ No

6. If you answered YES to Q5, does your organization share management, employees, or governance structure with the sister company?
____ Yes
____No

7. If you answered YES to Q5, are any owners, employees, or agents of the sister company involved in the planning, development, or implementation of educational content?
____ Yes
____ No

8. If you answered YES to Q5, does the sister company control or influence, in whole or in part, the operations of your organization?

____ Yes
____ No

NOTE: If you answered YES to Q3-8, your organization would likely be defined by the ACCME Standards for Integrity and Independence in Accredited Continuing Education as an ineligible company.

Section 4: Statement of Understanding

On behalf of _____ 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 of _____, that _____ will comply with all eligibility requirements and approval criteria throughout the entire approval period, and that _____ will notify the American Society of PeriAnesthesia Nurses promptly if, for any reason while this application is pending or during any approval period, _____ 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 the American Society of PeriAnesthesia Nurses to deny, suspend or terminate _ 's approval of this individual activity and to take other appropriate action against

(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) **Date** _____

_____

Completed By: Name and Title

Please return the completed Eligibility Verification Form to
the American Society of PeriAnesthesia Nurses at: **ezeiger@aspan.org**.

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