Out-Of-State Nursing Education Prelicensure Program Substantial Equivalency Assessment Tool (Initial)

(Must be completed by a Nursing Program Administrator ONLY-not a graduate)

The Maryland Board of Nursing must review and approve an applicants' out-of-state prelicensure program. This is in accordance with our Code of Maryland Regulations (COMAR) Definition of Substantial Equivalency 10.27.01.01(C) and, Nursing Education Programs 10.27.03. This one-time assessment is completed to determine substantial equivalency to Maryland Approved in-state Nursing Education Program.

Completing this assessment tool will assist the Board of Maryland Education Consultant staff's review of your prelicensure program. Please include appropriate documentation, i.e., catalog information, syllabi, or website information to support the information you submit.

***Forward Completed Application and Supporting Materials To: ***

Mail:
Director of Education and Examination
Maryland Board of Nursing
4140 Patterson Avenue Baltimore, MD 21215-2254

Email (preferred):
mbon.educationprograms@maryland.gov
Allow 21 business days for review completion upon receipt of **all** required supporting documents.

Date Received: Date Reviewed:

_____

Nursing Program Consultant completing review:

_____

Name and full address of controlling institution:	Name: Address: Address: City, State, Zip code:
Name and full address of the nursing program:	Name: Address: Address: City, State, Zip code:
Nursing contact person's name, title, telephone number and email address:	Name: Title: Phone: Email:

Is the controlling institution a member of the National Council for State Authorization Reciprocity Agreement (NC-SARA, also called SARA)? YES ☐ NO ☐	
Degree/certificate conferred to students:	
NCSBN Program Code	
Type of nursing program: **Classroom** ☐ **Online**☐ **Hybrid** ☐	
Length of nursing program:	

ACCREDITATION/APPROVAL

Is the nursing program accredited?   **YES** ☐   **NO** ☐ **If so, state the name of the accrediting agency and the accreditation date:** *Ex" ACEN, CCNE, NLN,CNEA* *Submit Letter or Certificate*
(*If the controlling institution has an LPN and RN education program and only one of the programs is accredited*) **attach an addendum to the accredited program's self-study describing the unique components of the non-accredited program:**   **N/A** ☐   **SEE ATTACHED** ☐
Has the nursing program received approval from the appropriate state nursing Board? If yes, state the name of the nursing Board and the date of approval. **YES** ☐   **NO** ☐ *Submit Letter or Certificate of Good Standing*
Is the controlling institution accredited?   **YES** ☐   **NO** ☐ **If so, state the name of accrediting agency and the accreditation date:** *Ex: Middle States Commission on Higher Education, New England Commission of Higher Education*

NURSING PROGRAM ADMINISTRATOR (Please attach CV)	
Name and contact information for the Nursing Program Administrator:	**Name:** **Address:** **Address:** **City, State, Zip code:** **Phone:** **Email:**
Is the Nursing Program Administrator currently licensed as an RN? YES ☐ NO ☐ **State of Licensure:** **License number:**	
Does the Nursing Program Administrator have a graduate degree in nursing? YES ☐ NO ☐	
Briefly describe the responsibilities of the Nursing Program Administrator or attach the job description:	
If the Nursing Program Administrator is required to teach, briefly describe the teaching load that he/she will carry (omit information if included in the job description):	

FACULTY POLICIES	
If the program administrator is required to teach, the program administrator carries a minimal teaching load. *COMAR 10.27.03.09B*	
How many faculty are full time?	
How many faculty are adjunct?	

COOPERATING AGENCIES
Have the agencies that provide the facilities used for clinical learning experiences ("Cooperating Agencies") been approved by the appropriate authorities? If yes, state the name of the approving authority and the date of approval. Also indicate whether the approval is full, conditional, or provisional: *Ex: Middle States Commission on Higher Education, New England Commission of Higher Education*   FULL ☐　　　　CONDITIONAL ☐　　　　PROVISIONAL ☐
Are there written agreements in place between the nursing program and the Cooperating Agency that specify the responsibility of the program to the Cooperating Agency and the responsibility of the Cooperating Agency to the program? If yes, please attach (*Template or Sample)* YES ☐　　　　NO ☐
STUDENTS
Indicate (Y/N) whether the following is available to students: ● **a written statement of students' rights and responsibilities YES ☐　　NO ☐** ● **the opportunity to participate in program development and evaluation.** 　**YES ☐　　NO ☐** ● **a written grievance/complaint mechanism　YES ☐ NO ☐** ● **guidance and advisement services　YES ☐　　NO ☐** ● **Provide a link to the Student Handbook:** ● **What support faculty, programs or resources does the nursing program provide their students?**