Board of Nursing

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

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.

Name and full address of controlling institution:	Name: Click here to enter text. Address: Click here to enter text. Address: Click here to enter text. City, State, Zip code: Click here to enter text.
Name and full address of the nursing program:	Name: Click here to enter text. Address: Click here to enter text. Address: Click here to enter text. City, State, Zip code: Click here to enter text.
Nursing contact person's name, title, telephone number and email address:	Name: Click here to enter text. Title: Click here to enter text. Phone: Click here to enter text. Email: Click here to enter text.
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:	Click here to enter text.
Type of nursing program: Classroom ☐	**Online ☐** **Hybrid ☐**
Length of nursing program:	Click here to enter text.
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)* Click here to enter text.	

(*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. (*Submit Letter or Certificate of Good Standing)* YES ☐   NO ☐

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* Click here to enter text.

Nursing Program Administrator **(Attach CV)**

Name and contact information for the Nursing Program Administrator:	**Name:** Click here to enter text. **Address:** Click here to enter text. **Address:** Click here to enter text. **City, State, Zip code:** Click here to enter text. **Phone:** Click here to enter text. **Email:** Click here to enter text.

Is the Nursing Program Administrator currently licensed as a RN? YES ☐   NO ☐

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: Click here to enter text.

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): Click here to enter text.

Faculty Policies

If the program administrator is required to teach, the program administrator carries a minimal teaching load. *COMAR 10.27.03.09B*	Click here to enter text.
Number of full-time faculty	Click here to enter text.
Number of adjunct faculty	Click here to enter text.

Cooperating Agencies

Have the agencies that provide 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*   Click here to enter text.   **FULL** ☐   **CONDITIONAL** ☐   **PROVISIONAL** ☐
Are there written agreements 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:** Click here to enter text.   ● **What support faculty, programs or resources does the nursing program provide their students?**   click here to enter text

***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):**mdbon.nbexam@maryland.gov –Allow 21 business days for review completion

Date Received: **Date Reviewed:**

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Nursing Program Consultant completing review:

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Approved By the Board of Nursing: YES ☐   **NO** ☐