



Arkansas Department of Health

Arkansas State Board of Nursing

1123 S. University Ave., #800 • Little Rock, AR 72204

(501) 686-2700 • Fax (501) 686-2714

NEW EDUCATION PROGRAM PROPOSAL APPLICATION OF INTENT

Contact Information

Program Name: _____
 Name of Program Administrator: _____
 Program Address: _____
 City _____ State _____ Zip _____
 Program Phone: _____ Program Website Address: _____
 Program Administrator Email: _____

Program Information

Authorized by the Arkansas Division of Higher Education (ADHE)? Yes No
 If not already authorized by ADHE, an application has been submitted. Yes No N/A
 The parent institution meets the transfer or articulation requirements for courses in Arkansas education institutions. Refer to ADHE Act 747 Arkansas Transfer and Articulation (ATAA). Yes No
 If parent institution is located outside of Arkansas jurisdiction, program is approved/accredited by the Board of Nursing or equivalent in the state where parent institution originates. Yes No
 Accredited by an accrediting body recognized by the US Secretary of Education? Yes No

Name of accrediting body: _____

Type of Program to Start: Practical Nursing Associate Degree RN Baccalaureate RN Direct Entry MSN

- Projected date for first admission: _____
- Projected student enrollment: _____
- Number of classes admitted yearly: _____
- Length of program: _____
- Anticipated date of completion for first class: _____

___ I have read and understand the requirements for nursing education programs in Arkansas and will meet all expectations at time of feasibility study submission (NPA §17-87-401 and Part 125).

Email this completed form to Dr. Brandy Haley at brandy.haley@arkansas.gov.

If you are only requesting a new satellite campus for the above program, please mark this box.

Signature

 Program Administrator Signature Date

 Print Administrator name, credentials and title Date