Mississippi Board of Nursing

713 S. Pear Orchard Rd., Plaza II, Suite 300, Ridgeland, MS 39157

Application for Approval of Program Changes

Existing Practical Nursing Program

Program Identification

Institution Name:

Governing Body:

Campus Location:

Program Director:

Phone Number:

Email Address:

Date of Submission:

Anticipated Date of Implementation:

Approval and Accreditation Status

Institutional Accrediting Agency:

Last Mississippi Board of Nursing Site

Visit/Status: Nest Scheduled Review:

Current NCLEX-PN® First-Time Pass Rate:

Current Program Completion Rate:

Proposed New Program Option

Anticipated Implementation Date:

First Cohort Start Date:

Projected First Cohort Size:

Primary Delivery Location (s):

Type of Program Change Requested

(Check all that apply)

☐ **New Location** (e.g. Establishing an additional site/campus)
☐ **Physical Location Change** (e.g. Relocation within the same campus or facility)
☐ **Alternate delivery format** (e.g. Hybrid, curriculum change)
☐ **Program Expansion** (e.g. Increase in enrollment, cohort size, or instructional capacity)
☐ **New Program Option** (e.g., day/evening/weekend option)
☐ **Other (describe)**_____

Description of Proposed Change(s)

Provide a detailed narrative description of the proposed change(s), including the rationale and anticipated implementation date.

_____
_____
_____
_____

Justification and Need for Change

Provide evidence demonstrating need and demand for the option. (Examples: applicant/wait-list trends, employer or workforce data, advisory committee input, community need, and letters of support).

_____
_____
_____
_____

Impact on Program Operations

Students

Describe how the proposed change(s) will impact current and prospective students.

_____
_____
_____
_____

Faculty and Staff

Identify additional faculty and support staff needed, including recruitment timeline and contingency plan for vacancies.

Provide the projected faculty-to-student needs for this option and explain how sufficient qualified faculty will be maintained.

Curriculum

Confirm whether the approved curriculum will remain unchanged. If changes are proposed, describe them.

☐ No curriculum changes
☐ Curriculum changes proposed (attach documentation)

Facilities and Resources

Describe classrooms, laboratories, simulation facilities, equipment, and learning spaces available to support the option.

Clinical Resources

Describe how clinical placement for the new option will affect existing students, other program options, and other nursing programs using the same agencies.

List the proposed clinical agencies/settings and the type of experiences each will provide.

Enrollment and Capacity

(Required for Expansion or New Program Option)

Current Approved Enrollment Capacity: _____
Proposed Enrollment Capacity: _____

Provide data supporting the program's ability to support the proposed enrollment or option.

_____
_____
_____

Outcomes and Evaluation

Describe how the program will monitor and evaluate the impact of the proposed change(s) on student outcomes, including completion rates, licensure outcomes, and program effectiveness.

_____
_____
_____
_____

Assurance of Compliance

By signing below, the program and institution attest that the information submitted is accurate and complete; that sufficient qualified faculty, clinical learning experiences, facilities, technology, student services, and financial resources will be available to support the proposed option; and that the option will not be implemented before all required approvals are obtained.

Program Director/Administrator Signature:

Title:

Date:

Attachments Checklist

☐ Narrative description of change(s)
☐ Implementation timeframe
☐ Facility documentation (if applicable)
☐ Faculty roster (if applicable)
☐ Evidence of clinical site availability/commitment, as applicable
☐ Evidence of need/demand for the option
☐ Enrollment data and projections
☐ Any additional supporting documentation
☐ Floor plans, as applicable
☐ Equipment and resource inventory