# Curriculum Change Request Form

## Adult-Gerontology CNS Program

### (Wellness through Acute Care)

AACN CERTIFICATION CORPORATION

*Certification Organization for the American Association of Critical-Care Nurses*

***This form is used to communicate course changes after the curriculum has been verified by AACN Certification Corporation***

**School Name:**

**School City/State:**

Program is accredited through: ☐ CCNE ☐ ACEN

Adult-Gerontology CNS track(s) offered: ☐ Master's ☐ DNP ☐ Post-Graduate Certificate

Instructional format: ☐ Primarily Face-to-Face ☐ Primarily Distance Learning ☐ Hybrid

Below changes apply to these tracks: ☐ Master's ☐ DNP ☐ Post-Graduate Certificate

Below changes went/go into effect on: _____ (mm/dd/yy)

**Please list only course details that have changed.**

| Didactic Course *Changes* | Course Number(s) | Course Type * D or D/C | Number of Credit Hours |
|---|---|---|---|
| Advanced Pathophysiology | | | |
| Advanced Pharmacology | | | |
| Advanced Physical Assessment | | | |
| Adult-Gerontology Wellness through Acute Care | | | |
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***Course Type:**
**D**: Didactic
**C**: Clinical
**D/C**: Didactic/Clinical

| Clinical Course *Changes* | Course Number(s) | Course Type * C or D/C | Number of Credit Hours | Number of Clinical Hours |
|---|---|---|---|---|
| Adult-Gerontology Wellness through Acute Care | | | | |
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☐ The required minimum 500 clinical hours do not include time in simulation or skills labs.

**Notes:** *(Use this section to capture prior course info. that was replaced by info. added above and/or to clarify your requested changes.)*

**Information on this form provided by:**

**Program Director Signature:** **Date:**

**Printed Name:** **Email:**

**Title:** **Phone:**

*Return this completed form via email to APRNcert@aacn.org along with **syllabi** for any **new or significantly modified** courses listed.*