

Curriculum Change Request Form

Neonatal CNS Program (Wellness through Acute Care)

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

Neonatal 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	_____	_____	_____		
Neonatal Wellness through Acute Care	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
	_____	_____	_____		
Clinical Course Changes	Course Number(s)	Course Type * C or D/C	Number of Credit Hours	Number of Clinical Hours	
Neonatal Wellness through Acute Care	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	
	_____	_____	_____	_____	

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.