



Thank you for your interest in applying for the APIC® Program of Distinction.

Facilities that meet the eligibility requirements must submit all three application parts plus application fee in order to submit a completed application.

Application Parts 1 and 2 should be emailed to podapplications@apic.org. The required application fee should be mailed to the address below. Once these items are received, applicant will receive an email with a link to a secure, HIPAA-compliant website, where applicant can upload the required documents listed in Part 3.

Once the required documents in Part 3 have been received applicant will receive an email confirmation.

Please make checks payable to **APIC Consulting Services**, and mail to:

APIC Consulting Services, Inc
Attn: APIC® Program of Distinction
1400 Crystal Drive, Suite 900
Arlington, VA 22202

Have a question about the APIC® Program of Distinction, the application or the application process?

Email us at podapplications@apic.org.

This application has three parts:

- ▶ PART 1: Demographic Data
- ▶ PART 2: Personnel Information
- ▶ PART 3: Required Documents

ELIGIBILITY REQUIREMENTS

Eligible facilities are general acute care facilities, including specialty facilities, that meet the following criteria:

- In operation for at least five years
- In compliance with all applicable federal, state, and local laws and regulations that apply to acute care facilities
- Licensed by the state and certified by the Centers for Medicare and Medicaid Services (CMS)

In addition, it is desirable to be accredited by bodies such as The Joint Commission (TJC), Det Norske Veritas-Germanischer Lloyd (DNV GL), or other providers of deemed status.

- Have at least one infection preventionist (IP) on staff who is board certified in infection prevention and control
- Have an Infection Prevention and Control Department in which all IPs with five or more years of experience are board certified in infection prevention and control



► PART 1 **Demographic Data**

Primary Contact for APIC® Program of Distinction

Name: _____

Title: _____

Phone: _____

E-mail address: _____

Invoicing Contact

Name: _____

Title: _____

Phone: _____

E-mail address: _____

FACILITY DEMOGRAPHICS

Facility legal name: _____

Doing business as (if different from legal name): _____

Legal address: _____

Facility website address: _____

Organization type

(check all that apply):

- ☐ For profit
- ☐ Not-for-profit
- ☐ Community-based
- ☐ University
- ☐ Government
- ☐ Physician-Owned
- ☐ Teaching
- ☐ Research

Facility designated as:

- ☐ General Acute Care Facility
- ☐ Critical Access Hospital
- ☐ Children's Hospital
- ☐ Long-Term Acute Care
- Other (describe) _____
- _____
- _____

Accreditation/Certification

(check all that apply)

- ☐ Centers for Medicare and Medicaid Services (CMS)
- ☐ Det Norske Veritas-Germanischer Lloyd (DNV GL)
- ☐ International Organization for Standardization (ISO)
- ☐ The Joint Commission (TJC)

Licensed beds: _____

Average daily census: _____

Total FTEs: _____



ORGANIZATIONAL STRUCTURE

Which best describes your facility structure:

- ☐ A single, stand-alone facility that is not part of a healthcare system
- ☐ Part of a multi-site healthcare system with governance at both the system and local levels
- ☐ Part of a multi-site healthcare system in which each site has decision-making autonomy
- ☐ Part of a matrix system in which some functions are centralized at the system level, and others are local

Other (describe) _____

If applicant is a multi-site healthcare system, list all sites that are recognized as part of the hospital business or licensure (i.e., include all sites that are included in your accreditation process.)

If additional space is needed, please attach a separate document. Check here to confirm a separate document has been added ☐.

Site Name	Services Provided	Address	Distance from main site	Number of FTEs



ORGANIZATIONAL LEADERSHIP (STAND-ALONE FACILITY)

NAME OF HOSPITAL FACILITY:

Chief Executive Officer

Name: _____

Phone: _____

E-mail: _____

Chief Nurse Executive

Name: _____

Phone: _____

E-mail: _____

Director of Quality

Name: _____

Phone: _____

E-mail: _____

Chief Medical Officer

Name: _____

Phone: _____

E-mail: _____

Infection Preventionist (Lead)

Name: _____

Phone: _____

E-mail: _____



ORGANIZATIONAL LEADERSHIP (MULTI-HOSPITAL SYSTEM)

NAME OF HOSPITAL SYSTEM:

Chief Executive Officer

Name: _____

Phone: _____

E-mail: _____

System or Facility Level: _____

Chief Nurse Executive

Name: _____

Phone: _____

E-mail: _____

System or Facility Level: _____

Director of Quality

Name: _____

Phone: _____

E-mail: _____

System or Facility Level: _____

Chief Medical Officer

Name: _____

Phone: _____

E-mail: _____

System or Facility Level: _____

Infection Preventionist (Lead)

Name: _____

Phone: _____

E-mail: _____

System or Facility Level: _____



Patient Care Services Provided

Indicate the services that your facility provides, as well as the number of visits and/or number of beds.

Service Line	Service Provided (check if yes)	Number of Beds
Alcohol Drug Abuse/Dependency		
Behavioral Health		
CRITICAL CARE UNITS:		
- Burn Unit		
- Medical Cardiac		
- Medical/Surgical		
- Mixed Acuity		
- Pediatric		
- Neonatal		
- Neurosurgical		
- Respiratory		
- Surgical Cardiothoracic		
- Surgical		
- Trauma		
Emerging Infection Treatment Unit		
Hemodialysis		
Long Term Acute (LTAC)		
Medical		
Medical/Surgical		
Obstetrics/Labor & Delivery		
Oncology		
Orthopedics		
Pediatric		
Rehabilitation		
Surgical		
Transplant Services		
- Inpatient Bone Marrow Transplant		
- Inpatient Solid Organ Transplant		
Other Inpatient Services (specify)		
Other Inpatient Services (specify)		



Operative and Invasive Procedure Units

Indicate the services provided at your facility, as well as the number of operating/procedure rooms, and the annual number of procedures performed.

Type of Service	Service Provided (check if yes)	Number of Rooms	Number of Annual Procedures
Ambulatory Surgery			
Cardiac Catheterization			
Endoscopy			
Interventional Radiology			
Surgery			
Other (specify)			

Support Services

For each service below, indicate if it is provided onsite (within your facility) or offsite (outside of your facility). If the service is provided by a contract agency, include the agency name.

Department	Onsite	Offsite	N/A	Contract Service? (If yes, include name of contractor)
Central/Sterile Processing Services				
Clinical Laboratory				
Diagnostic Imaging				
Employee/Occupational Health				
Environmental Services				
IV Therapy				
Linen Services				
Nutrition and Dietetics				
Pharmacy				
Physical/Occupational Therapy				
Plant Operations/Maintenance				
Respiratory Care				
Other				
Other				



Ambulatory Services

For each service, indicate number of separate locations, total number of annual visits, and indicate if there are high level disinfection, sterilization, or invasive procedures performed by those services.

Department	Number of Locations	Total Number of Annual Visits	Check if High Level Disinfection, Sterilization, or Invasive Procedures Occur
Ambulatory Clinic			
Emergency Department			
Dialysis			
Primary Care Services or other Physician Practices			
Urgent Care			
Other Ambulatory Services (specify)			
Other Ambulatory Services (specify)			



► PART 2 **Personnel Information**

Infection Prevention and Control Department Personnel

List the full name of all infection preventionists (IPs) and, if applicable, their dates of certification. As noted in the eligibility requirements above, there must be one IP board certified in infection prevention and control on staff.

IP Name	Title	Years of Experience	Certification Dates (20XX to 20XX)

Additional Infection Prevention and Control Department Personnel

List additional positions that are part of the Infection Prevention and Control Department's direct cost center or budget (e.g., data analyst, hospital epidemiologist, physician director, etc.). Identify each individual's role and experience.

Title/Credential	Role	Years of Experience



Personnel Experience and Continuing Education

Are all IPs with 5+ years of experience board certified in infection prevention and control?

If not, the site is not eligible for assessment.

Do all non-certified IPs with 3-5 years of experience have an established plan to become board certified in infection prevention and control? This plan might include annual evaluation, personal goals, a competency self-evaluation plan or certification review enrollment. **If not, the site is not eligible for assessment.**

IP Name	Experience/CE	Certified (yes/no)	Percentage of time dedicated to IPC Dept

Provide relevant continuing education (CE) in the past year for all positions listed above.

IP Name	CE Completion	Year	Percentage of time dedicated to IPC Dept



► PART 3 **Required Documents**

Once application Parts 1 and 2 have been submitted with application fee, applicant will receive an email with a link to a secure, HIPAA-compliant site where applicant can upload the required documents listed below. Once submission is complete, applicant will receive an email confirmation.

Program Standard	Required Documents*	Submitted
Surveillance	Organizational surveillance plan (may be part of infection prevention and control plan)	
	Organizational infection control risk assessment	
	12 months of surveillance (outcome and process) data	
	Example of surveillance reporting to leadership	
	Annual infection prevention program evaluation	
Hand Hygiene	Organizational policy for hand hygiene	
	Organizational competency and monitoring plan	
	12 months of hand hygiene monitoring data	
Unusual Occurrences and Outbreak Investigations	Outbreak investigation policy/procedure	
	Unusual (sentinel) occurrence policy/procedure	
	Example of investigation related to infection prevention (if occurred within last two years)	
	Example of root cause analysis	
Isolation Practices	Policy for transmission-based precautions	
	Policy for standard precautions	
	Policy for reducing the risk for multidrug-resistant organisms	
Low-level Disinfection	Policy for cleaning patient equipment	
	Staff education plan for cleaning patient care equipment	
	Policy on cleaning and storing patient care equipment	
	A procedure that addresses storage of cleaning equipment	



Program Standard	Required Documents*	Submitted
High-level Disinfection	Policy for processing endoscopes and cleaning validation	
	Policy for recall of items when there is a process failure	
	Policy for high-level disinfection	
	Example of education and annual competency assessment of staff who perform high-level disinfection	
Sterilization of Reusable Instruments, Devices, and Patient Care Equipment	Policy for sterilization of reusable instruments	
	Cleaning, disinfection, and sterilization competency validation procedures	
	Policy for patient disclosure, testing, reporting, and follow-up on failed biological indicators, recalls, or FDA/CDC alerts	
Facility/Environment	Construction policy	
	Infection prevention environmental safety rounds checklist	
	Safety round report and action plan	
	Critical room ventilation, temperature, or humidity monitoring plan or policy	
	Water management program plan or policy	
	Environmental monitoring/plan for cleaning	
	Sterile compounding clean room environment monitoring plan	
	Latest state report for food preparation areas	
	Documentation of laundry visit in calendar year	
Emergency Management	Emergency management plan, which addresses basic infrastructure, biologicals, and specifics to infectious diseases	
	Crisis standards of care that address policies/procedures impacting spread of infection during disasters	
	Example of an evaluation of an emergency management drill	



Program Standard	Required Documents*	Submitted
Employee Health	Immunization policy, including information about each vaccine included in the employee health policies	
	Post-exposure management policy	
	New employee and annual employee screening policies	
	Infectious disease exposure management policies: <ul style="list-style-type: none"> - Blood and body fluid - TB - Pertussis - Meningitis 	
	Infectious disease work restriction guidelines	
	Annual TB risk assessment and TB control plan	
	Bloodborne pathogen exposure control plan	
Antibiotic Stewardship Program	Organizational policy on antimicrobial stewardship	
	Policies, protocols, pathways, or order sets that limit antimicrobial use or specify correct use, with one or two examples (e.g., standard pre-operative surgical prophylaxis order sets, pathways, or other standard protocols for recommended antimicrobial prophylaxis)	

***Note: Please be sure that all documents are available electronically or in hard copy during your site visit.**

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