HAWAII STATE BOARD OF NURSING
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P.O. BOX 3469, Honolulu, Hawaii 96801

ANNUAL REPORT FORM FOR HAWAII NURSING PROGRAMS

Due Date: OCTOBER 1st

Name of Nursing Program/School/College:
Mailing Address (include apt. no., city, state and zip code):
Name of Contact Person:
Phone Number and Email address of contact person:

Type of Nursing Program

For period covering past academic year _____ to _____ (please indicate the dates of your last academic year covered by this annual report). Indicate all nursing programs and pathways offered during the report period (mark all applicable boxes):

- ☐ **LPN**
- ☐ **LPN to ADN/ASN**
- ☐ **LPN to BSN**
- ☐ **ADN**
- ☐ **BSN**
- ☐ **RN to BSN**
- ☐ **RN to MSN**
- ☐ **Pre-licensure Graduate Entry Program (Pre-lic GEPN) completion**
- ☐ **Master's in Nursing**
- ☐ **BS/BSN in Nursing to DNP**
- ☐ **MSN/MS in Nursing to DNP**
- ☐ **Other, please specify:** _____

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This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

Name of Nursing Program/School/College: _____ Date: _____

Program's National Accreditation

Please attach a copy of the program's current national accreditation.

Student Information

For the following charts, "FT" = Full-time, "PT" = Part-time

Enrollment - Undergraduate Level:

Actual enrollment for past academic year _____ to _____ (please indicate the dates of your last academic year covered by this annual report).

	1st Year		2nd Year		3rd Year		4th Year	
Program Type:	FT	PT	FT	PT	FT	PT	FT	PT
LPN								
ASN/ADN								
LPN to BSN								
BSN								
RN to BSN								
Other, please specify: _____								

Enrollment - Graduate Level:

Actual enrollment for past academic year _____ to _____ (please indicate the dates of your last academic year covered by this annual report).

	1st Year		2nd Year		3rd Year		4th Year		5th Year		6th Year	
Program Type:	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
Pre-lic. GEPN												
RN to MSN												
MSN												
BS/BSN in Nursing to DNP												
MSN/MS in Nursing to DNP												
Other, please specify: _____												

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Name of Nursing Program/School/College: _____ Date: _____

Student Information - Continued

Graduates:

Graduates of past academic year _____ to _____ (please indicate the dates of your last academic year covered by this annual report).

Program Type:	Completion Date:	Completion Date:	Completion Date:	Completion Date:	Completion Date:
LPN					
ASN/ADN					
LPN to BSN					
BSN					
RN to BSN					
RN to MSN					
Pre-lic. GEPN					
MSN					
BS/BSN in Nursing to DNP					
MSN/MS in Nursing to DNP					
Other, please specify: _____					

Retention Rate - Please indicate the number of students who stay in the program. Also, please indicate how you determined your retention rate (attach on a separate sheet if necessary):

Program Type:	Current Year Date: _____		Past Year Date: _____	
	FT	PT	FT	PT
LPN				
ASN/ADN				
LPN/BSN				
BSN				
RN to BSN				
RN to MSN				
Pre-lic. GEPN				
MSN/MN/MS in Nursing				
Pre-advanced practice DNP				

Please explain any program retention rate below 80 percent. Provide what interventions are in progress to assess and address this rate? (attach on a separate sheet if necessary).

Name of Nursing Program/School/College: _____ Date: _____

Examination

NCLEX National Pass Rate ("NPR") for First-Time Test Takers:

Based on the G-4 report (Jurisdiction Program Summary of All First Time Candidates Educated in Jurisdiction of Licensure) for the past academic year _____ to _____ (please indicate the dates of your last academic year covered by this annual report). If the pass rate is below the NPR, as determined by the National Council of State Boards of Nursing, please indicate the following, in detail (attach on a separate sheet if necessary):

- Assessment

- Intervention or remediation

- Expected Outcomes

(CONTINUED ON PAGE 5)

Name of Nursing Program/School/College: _____ Date: _____

Faculty Information

Nursing Faculty - Please indicate the number of all compensated didactic and clinical faculty, including lecturers and adjunct faculty for last academic year covered by this annual report.

	FT	PT (permanent)	Adjunct or Temporary
RN			
Interprofessional			
Total			
Total FTE			

Non-nursing/Interprofessional Faculty - Please list the role and responsibilities of compensated non-nursing faculty in the nursing program for the last academic year covered by this annual report.

Name	Discipline	FT	PT	Role and Responsibility

All Newly Appointed Faculty

Please have all newly appointed faculty, including all full-time, part-time or adjunct hires, complete the *Faculty Application* form and attach a CV and certified transcript for each nursing degree granted.

Administrator's Attestation for all newly appointed faculty and continuing nursing faculty competency:

I have reviewed all newly appointed and continuing nursing faculty and verify that they have met all the requirements of Hawaii Administrative Rules section 16-89-45.

_____ _____

Print Name of Administrator Administrator's Signature

_____

Date

(CONTINUED ON PAGE 6)

Name of Nursing Program/School/College: _____ Date: _____

Program Information

Discuss any significant changes to: (You may explain on a separate sheet)

- Philosophy/Purposes of the program

- Organization/Administration of the program

- Curriculum

- Other changes relevant to the program

(CONTINUED ON PAGE 7)

Name of Nursing Program/School/College: _____ Date: _____

Curriculum for Entry Level Practice

Program Type	Total non-nursing credits (core, prerequisites, etc.) required	Total nursing credits required	Classroom/online/ didactic nursing credits required	Lab/clinical/simulation credits required
LPN				
ASN/ADN				
LPN to BSN				
BSN				
Pre-lic. GEPN				

Curriculum for Entry Level Practice - Continued

Program Type	Percentage of lab/clinical credits to total program credits (NOTE: HRS Ch. 89 requires 40%)	Faculty to student ratio: Lab hours	Clinical hours	Simulation hours
LPN				
ASN/ADN				
LPN to BSN				
BSN				
Pre-lic. GEPN				

Please indicate the number of contact hours per semester for:

One semester academic credit = _____ contact hours semester

One semester lab credit = _____ contact hours per semester

One semester clinical credit = _____ contact hours per semester

One semester lab/clinical credit = _____ contact hours per semester

Electronic Simulation Use

Please indicate types of simulation used within your program (mark all that apply). For purposes of this report, "High fidelity" electronic simulation utilize very realistic materials and equipment to represent the nursing intervention that the student must perform.

	Yes, please indicate number of hours	No
Is high fidelity electronic simulation substituting for clinical (live patient) encounter?		
Is high fidelity electronic simulation substituting for lab hours?		

Print Form