**Nursing Continuing Education Program**

**External Application Process**

Thank you for your interest in the application process for continuing education contact hours. You can use this packet to assist you in the process. Please read each section carefully as incomplete forms significantly delay approval. If you have questions or problems interpreting the directions, please call for assistance.

Included:

1. Application Checklist
2. Application fee schedule
3. Application instructions
4. Application form
5. Sample program outline
6. Sample Program Advertising
7. Sample attendance sheet
8. Sample evaluation form
9. Sample Financial Disclosure Form
10. Verb list for writing education objectives

## Rules for Applying

* **Complete application and payment, if required must be submitted at least 60 days prior to the activity.**
* Applications will not be processed until all required components and the application fee are received.
* During processing, we will contact the applicant via email if we require additional information.
* If an applicant has to be asked for additional information after the second submission, reprocessing fees will occur.
* The applicant will be notified by email when the review process is complete whether the application has been approved or not.

Sincerely,

Susan Hatfield, MSN, MEd, RN

Nursing Continuing Education Program

*Center for Professional Growth and Innovative Practice*

[CE-Program@UCHealth.com](mailto:CE-Program@UCHealth.com)

(513)584-0233

**University of Cincinnati Medical Center**

234 Goodman Street ML 0722

Cincinnati, OH  45219-2316

cid:image002.png@01CDE9BC.CD60D090

***UC Health is an OBN Approver/Provider Unit through the Ohio Board of Nursing (OBN-007-92)***

**Nursing Continuing Education External Application Checklist**

|  |  |
| --- | --- |
| **PRIOR TO SUBMISSION** | |
|  | Application submitted at least 60 days prior to initial offering |
|  | Application fee included |
|  | A single presentation date requested on the application (any additional offerings of the presentation must be submitted individually at least two weeks prior to the presentation date) |
|  | Signed Financial Disclosure form is completed, signed, and included for EVERY planning committee member and presenter |
|  | Draft of Advertising – must be provided prior to approval (an actual flyer or brochure - not a list of items that will be included on a potential flyer/brochure) |
|  | Draft of presentation materials – must be provided prior to approval ( |
|  | |
| **POST PROGRAM REQUIREMENTS** (Within two weeks after presentation) | |
|  | Sign in sheets and summary of evaluations are to be returned via email to [CE-Program@UCHealth.com](mailto:CE-Program@UCHealth.com) and [Jo.Claar@UCHealth.com](mailto:Jo.Claar@UCHealth.com) |
|  | The CE # is included in the subject line of the email |
|  | Any scanned documents are scanned separately and saved as PDFs with names that include the CE # and date of offering. Examples: 1NSCE842SignIn06March2015.doc or 1NSCE842SummEval06March2015.doc |
|  | Summary of Evaluations includes the CE #, title of the program, and the correct date of the offering. (each offering requires a separate summary of evaluations, you CANNOT combine offerings into one summary of evaluations) |
|  | Sign-In sheet includes the CE #, title of the program, and the correct date of the offering. (each offering requires a separate sign-in sheet, you CANNOT combine offerings into one sign-in sheet) |
|  | |
| **ADDITIONAL OFFERINGS** (At least two weeks prior to additional offering) | |
|  | Documentation for all prior offerings has been submitted. (No additional offerings will be approved unless all paperwork is up to date.) |
|  | Send an email Request for additional offerings to [ce-program@uchealth.com](mailto:ce-program@uchealth.com) |
|  | Include the CE # and Program title in the subject line of the email |

**APPLICATION FEES - EXTERNAL**

**CONTINUING EDUCATION CONTACT HOURS**

**Effective 10/23/2014**

1. **Faculty Directed CE Activity Approval**

|  |  |
| --- | --- |
| 0.5 to 3 Contact Hours | $100.00 |
| All Day | $200.00 |
| 2 to 3 Days | $275.00 |
| Over 3 Days | Call For Fee |

2. **Independent Study**

|  |  |
| --- | --- |
| 1 to 2 Contact Hours | $100.00 |
| 2 to 5 Contact Hours | $200.00 |
| Over 5 Contact Hours | Call For Fee |

3. **Entire CE Provider Approval**

|  |  |
| --- | --- |
| Initial Approval | $700.00 |
| Re-Approval | $550.00 |

**Check Payable to: University of Cincinnati Medical Center**

**Mail to:**

CE Program

Center for Professional Growth and Innovative Practice

University of Cincinnati Medical Center

234 Goodman Street

Mail Location 0722

Cincinnati, OH 45219-2316

**APPLICATION INSTRUCTIONS FOR CONTINUING EDUCATION FACULTY DIRECTED ACTIVITY**

An approved educational activity may be presented once or repeated during the two-year period of approval.

Use the attached application form when seeking approval. **Applications must be received at least sixty days prior to the program date.** Applications are reviewed by UC Health CE committee peer reviewers. Applicants will be notified via email of the approval status.

**Educational Standards and Guidelines for a CE Activity**

1. **Planning Committee**

1. Licensed nurses representing the target audience must be included on the planning committee. When registered nurses, licensed practical nurses, and dialysis technicians are included in the target audience, all must be represented on the planning committee. One person on the committee is administratively responsible for the activity. *Applicant must submit names, credentials and titles of nurses/dialysis technicians on planning committee.*

2. **Needs Assessment/Target Audience**

1. The activity is planned based on a documented need assessment related to topic and its relevance to intended audience.
2. Identify target audience.

*Applicant must describe the intended target audience.*

3. **Faculty Credentials**

1. Faculty must be qualified to present the activity.
2. Applicant must list faculty name, educational preparation, current position and professional qualifications specific to the topic being presented. Use the form provided. DO NOT ATTACH ENTIRE RESUME.

4. **Adult Learning Principles**

1. Adult Learning Principles shall be reflected in all aspects of the activity.
2. Applicant must identify ways in which adult learning principles were/will be utilized in planning and implementing the activity.

**NOTE:**

Information related to criteria #5 (outcomes), #6 (content/time frame), and #7 (teaching methods) must be submitted on form entitled *CE Activity Approval Form* (page 11 of the application).

5. **Objectives**

1. Objectives for the activity must be stated in behavioral terms that define expected outcomes for the learner. *Applicant must state objectives in behavioral terms.*

6. **Content/Time Frame**

1. Content must be appropriate to the objective.

***Each objective has corresponding content.***

1. Time allotted must be appropriate for content being presented.
2. Faculty/participant ratio must be identified.

*Applicant must provide a brief description of content in outline form. A time period must be presented for each topic (include breaks). Identify faculty member who will address content and proposed faculty/participant ratio.*

7. **Teaching Methods**

1. Teaching methods are congruent with the activity objectives and content.

*Applicant must list teaching methods for each topic or content area.*

8. **Evaluation**

There is a clearly defined method for evaluating the following:

1. Learner’s achievement of each behavioral objective
2. Teaching effectiveness of each faculty presenter
3. Effectiveness of teacher’s methods
4. Relevance of content to professional practice

*Applicant must describe method used to evaluate activity and submit a copy of the evaluation form.*

9. **Co-Provider Agreement**

There is a written co-sponsor agreement which clearly identifies the CE provider as responsible for meeting and maintaining Board Standards for the following: budget, determination of objectives and content; selection of faculty; awarding contact hours; record keeping and evaluations.

10. **Financial Disclosure Form**

All planners, speakers and authors involved in the development of the CE content are required to disclose to the program provider their relevant financial relationships. *See the attached example* *and submit financial disclosure forms as appropriate*.

11. **Verification of Attendance and Successful Completion**

Criteria for verifying participation and successful completion must be determined as part of the overall planning of the activity. Educational activities may differ in expectation and requirements for verification of participation and successful completion of the activity. The learner is informed of these criteria prior to participation in the activity. Verification of participation may be achieved by a variety of methods; for example, roll call, sign-in sheets, self-reported attendance, or return of evaluation tools. Successful completion may be achieved by a variety of methods; for example, submission of a written post-test and a self-reported level of achievement of objectives, return demonstration, evaluation, discussion with presenters, attendance at the entire activity, etc.

12. **Certificate of Attendance**

CE certificate shall be provided to all participants who meet the requirements to receive contact hours. Certificates shall include:

1. Space for the name of attendee
2. Title of activity
3. Date of activity
4. Name of provider of CE activity
5. Name of OBN Approver and OBN Approver number
6. Number of contact hours
7. List of the objectives on the back of the certificate
8. When applicable, the number of Category A hours or the type of contact hours which meet CE requirements in a specified category (4723-8-10; 4723-23-06; 4723.485 of the Revised Code)

13. Once a CE program is approved, a CE certificate will be issued for the first time presentation of an activity with the following information:

* 1. original date of the activity
  2. length of presentation
  3. title of the activity
  4. the authorized OBN approval number
  5. name of the provider
  6. objectives of the activity
  7. number of contact hours awarded for the presentation

14. **Record Keeping**

Records must be kept for six years in a safe, secure and accessible manner.

This shall include:

1. A complete copy of all application data
2. All correspondence with the OBN Approver
3. A list of all attendees who were issued contact hours for each date the CE activity was offered which includes the number of contact hours granted to each
4. A summary evaluation for each date offered
5. Any changes made to the program during its approval period

*Applicant must submit a written statement of how records will be maintained.*

15. **Brochure/Flyer**

Applicant must submit a copy of the final brochure/flyer advertising the activity. MATERIAL MAY NOT ADVERTISE THAT APPROVAL STATUS IS PENDING OR HAS BEEN APPLIED FOR.

A suggested statement for advertising prior to program approval: “For information regarding contact hours call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at \_\_\_\_\_\_\_\_\_\_\_\_\_\_”.

16. **Appropriate fee must be submitted with each application.**



DEPARTMENT USE ONLY

Program #:

**# of Contact Hours:**

**Date Final:**

**Continuing Education**

**Application for Faculty Directed CE Activity**

**Title of Activity:** Click here to enter text.

**Name of Organization:** Click here to enter text.

**Date of the Activity:** Click here to enter a date.

**Name/Title of Person Responsible for CE Activity:** Click here to enter text.

**Work Address /ML:** Click here to enter text.

**Phone Number:**  Click here to enter text.

**Email:** Click here to enter text.

**Planning Committee**

* The planning committee is under the direction and includes one registered nurse.
* At least one licensed nurse if the target audience includes licensed practical nurse.
* At least on dialysis technician is required if the target audience focus includes dialysis.
* Please have name(s) and credentials below.
* Click here to enter text.

**Target Audience:** Click here to enter text.

**Needs Assessment:** How did you determine this program was needed? (Check ALL that apply.)

Management Request Formal Education Needs Assessment

New System, Equipment, or Regulation Quality Improvement Issue

Staff Request Trends in the literature and health care

Other, Describe: Click here to enter text.

**Adult Learning Principles:** Describe utilized during planning and implementation: (Check ALL that apply.)

Experienced Based Direct Application and Relevant To Job or Profession

Cooperative, Interactive Format Feedback is encouraged

Opportunity to Practice New Knowledge Other: Click here to enter text.

and Skills

**Verification of Participation and Successful Completion (check all that apply):**

Attendance will be verified at the event. If no, please explain: Click here to enter text.

Completion/submission of evaluation form

Other (please describe): (i.e. Post-test – both the test and key must be included with submission)

Click here to enter text.

**Participant must be informed of criteria prior to participation by:**

Information on brochure/advertising material (must show on brochure or advertising)

Verbal statement at the beginning of activity

Written information on handouts (must submit handouts to show)

Other (please describe): Click here to enter text.

**Co-providership:** Activity is co-sponsored: Check one: No Yes

According to the OBN 4723-14-01 "Sponsorship support" means monetary or in-kind support given by a non-commercial interest entity to the provider, or approved provider unit of a continuing education activity that is used to pay for all or part of the costs of a continuing education activity.

If yes, a copy of the co-sponsorship agreements included with the application. If applicable, please see below for the form, fill it out, print, sign, scan and return with it with this application.

Co-Sponsor Name: Click here to enter text.

Co-Sponsor Address**:** Click here to enter text.

**Primary purpose of this continuing education activity is to promote the sale of items or services:**

Check one: No Yes

(If the program purpose is to sell items or services it is not appropriate for approval of continuing education contact hours)

**Faculty Credentials**

Credentials shall include qualifications for all faculty members for the topic area to be presented. See Section 3 for an example of the required information.

1. **Name and Credentials:** Click here to enter text.
2. **Education (Where did you go to school?):** Click here to enter text.
3. **Current Position:** Click here to enter text.
4. **Professional qualifications specific to topic being presented:** Click here to enter text.
5. **Name and Credentials:** Click here to enter text.
6. **Education (Where did you go to school?):** Click here to enter text.
7. **Current Position:** Click here to enter text.
8. **Professional qualifications specific to topic being presented:** Click here to enter text.
9. **Name and Credentials:** Click here to enter text.
10. **Education(Where did you go to school?) :** Click here to enter text.
11. **Current Position:** Click here to enter text.
12. **Professional qualifications specific to topic being presented:** Click here to enter text.
13. **Name and Credentials:** Click here to enter text.
14. **Education(Where did you go to school?) :** Click here to enter text.
15. **Current Position:** Click here to enter text.
16. **Professional qualifications specific to topic being presented:** Click here to enter text.
17. **Name and Credentials:** Click here to enter text.
18. **Education(Where did you go to school?) :** Click here to enter text.
19. **Current Position:** Click here to enter text.
20. **Professional qualifications specific to topic being presented:** Click here to enter text.

**For External Applications Only:**

**Describe your record-keeping system:** *(see External Application directions, page 5, for specific requirements)*

Attach a copy of the brochure or flyer that will advertise the CE activity. If brochure is not yet complete, send a copy of the draft. Send the final brochure/flyer prior to the activity.

**NOTE: Contact hours MAY NOT be advertised prior to approval.**

**Statements such as “pending” or “applied for” MAY NOT be used.**

Attach a completed “CE Activity Approval Form” (see page 10)

# UC Health

# CE ACTIVITY APPROVAL FORM

**Title of Activity:** Click here to enter text.

**Date of Activity:** Click here to enter a date.

**PROGRAM #:** Filled in by CE approver only.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Outcome:**  List the outcome (s) in operational/behavioral terms using measurable verbs from the following page**.(Example: State the rules of delegation according to OAC 4723-13)** | **Content (topics):**  **Provide a detailed outline of the content** to be presented for each objective. | **Time Frame:**  State the time frame for the topic area, including breaks | **Faculty:**   * List the faculty or presenter for each topic * Include faculty/participant ratio. | **Teaching Method:**  Describe the teaching method(s) used for each objective. |
|  |  |  |  | Choose an item.  Choose an item.  Choose an item.  Choose an item.  Choose an item.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check Category of evaluation to be used:  Learner satisfaction  Knowledge enhancement  Skill & attitude change |
|  |  |  |  | Choose an item.  Choose an item.  Choose an item.  Choose an item.  Choose an item.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check Category of evaluation to be used:  Learner satisfaction  Knowledge enhancement  Skill & attitude change |
|  |  |  |  | Choose an item.  Choose an item.  Choose an item.  Choose an item.  Choose an item.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check Category of evaluation to be used:  Learner satisfaction  Knowledge enhancement  Skill & attitude change |
|  |  |  |  | Choose an item.  Choose an item.  Choose an item.  Choose an item.  Choose an item.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check Category of evaluation to be used:  Learner satisfaction  Knowledge enhancement  Skill & attitude change |

UC Health CONTINUING EDUCATION ATTENDANCE SHEET

**Activity Title:** Click here to enter text. **CE Activity #:** Filled in by CE approver only.

**Program Coordinator:**Click here to enter text. **Date:** Click here to enter a date.

# PLEASE PRINT

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **TITLE/ Credentials \*** | **EMPLOYEE ID#** | **FACILITY / UNIT or HOSPITAL** |
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Print clearly and include EIN. CE credit cannot be confirmed for an individual if we cannot read the name and EIN. **\* Must clearly indicate RNs vs *not* for correct totaling of Contact hours.**

**PROGRAM EVALUATION**

**UC HEALTH**

**CONTINUING EDUCATION**

**TITLE:** Click here to enter text. **CE Activity #:**Filled in by CE approver only.

**PROVIDER UNIT COORDINATOR: Amy Costanzo PhD, RN-BC Date:** Click here to enter a date.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **EXCELLENT** | **GOOD** | **POOR** |
| 1. Did this educational activity meet your personal and professional needs?  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 3 | 2 | 1 |
| 2. Will the content gained in the CE Activity be useful in your practice?  Comments: | 3 | 2 | 1 |
| 3. Was the faculty effective in:  (Each speaker must be listed: A,1,2; B,1,2; C,1,2; etc.)  A.  1. Knowledge of Subject   1. Method of Presentation (PowerPoints, lecture, activities etc.) 2. Instructor answered the questions effectively   A.  1. Knowledge of Subject   1. Method of Presentation (PowerPoints, lecture, activities etc.) 2. Instructor answered the questions effectively | 3  3  3  3  3  3 | 2  2  2  2  2  2 | 1  1  1  1  1  1 |
| 4. Did the content meet the following objectives: |  |  |  |
| A. | 3 | 2 | 1 |
| B. | 3 | 2 | 1 |
| C. | 3 | 2 | 1 |
|  |  |  |  |
| 5. Was this educational activity free of commercial bias?  Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | yes |  | no |
| 6. Will content learned change your clinical practice | yes |  | no |

7. Comment on how your practice will change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments/Suggestions:

**Advertising**

A draft of program advertising must be submitted with this application and include the following information:

* Title of Activity:
* Date:
* Time:
* Place:
* Disclosure Statement: There is no conflict of interest for anyone with the ability to control content for this activity.

**If not approved** for continuing education at the time you begin advertising, **please state the below.**

|  |
| --- |
| Please call (name of contact) at (telephone number or e-mail) for more information about contact hours. |

**Once the CE activity has been approved**, add the following wording:

This CE activity has been approved for **(fill in amount for course)** contact hours by the Ohio Board of Nursing through the OBN Approver Unit at UC Health.

(OBN-007-92)

**A FINAL VERSION OF THE ADVERTISING IS REQUIRED PRIOR TO APPROVAL**

**Agenda**

**Programs more than 2 hours long are required to have an agenda with breaks listed. If your program exceeds 120 minutes, please fill out the following table.**

|  |  |
| --- | --- |
| TIME | SUBJECT |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

POST TEST

**Any program that is recorded to be converted into an Independent Study for online learnersmust have a post-test.**

* List Five (5) multiple choice questions with correct answer highlighted that address expected outcome of objectives of the course presentation. These questions will be added to the module to evaluate learning objectives for each individual.

|  |
| --- |
| **An individual and separate FINANCIAL DISCLOSURE form must be signed by every planning committee member and presenter.** |

# UC Health CE Approver Unit

# Financial Disclosure Form

**In accordance with the UC Health Position on Commercial Support and UC Health and Ohio Board of Nursing standards, all planners, speakers, and authors involved in the development of continuing education (CE) content are required to disclose to the program provider their relevant financial relationships. An individual has a relevant financial relationship if he or she has a financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the CE activity content over which the individual has control. Relevant financial relationships will be disclosed to the activity audience.**

|  |  |
| --- | --- |
| Conference/Program Title: |  |
| Planner/Presenter/Content Expert Name: |  |

1. Does the CE content over which you have control contain information about healthcare products or services?

|  |
| --- |
| Yes  No (Answer is required.) |

If Yes, please move to question 2. If No, please sign a hard copy or if submitting electronically, type your last name in the signature box at the bottom of this form.

1. Regarding the healthcare products or services that will be discussed in the CE content over which you have control, have you had a financial relationship in any amount in the last 12 months with companies that produce these products or provide these services?

|  |
| --- |
| Yes  No (If Question 1 is Yes, you must answer Question 2.) |

If Yes, please complete the table below. If No, please sign a hard copy, or if submitting electronically type your name in the signature box at the bottom of this form.

If Question 2 is “Yes”, you must list at least one relationship in the table.

|  |  |  |  |
| --- | --- | --- | --- |
| Company or Service Provider | Nature of Relationship (e.g., independent contractor, employee, consultant, advisory board, research grant recipient [exceptions: non-profit or governmental organization, and non-healthcare related companies] non-CE speakers bureau, stockholder, etc. | Are you continuing to receive a financial benefit from this relationship? | If the relationship has ended, when?  MM/DD/YYYY |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |

Signature

I confirm that the information reported above is accurate. I understand that this information will be disclosed publicly in conference materials or publications, where appropriate. I further understand that the program provider reserves the right to replace me in an educational program, decline to publish my work, or otherwise limit my participation in this particular activity if they believe that a significant conflict of interest exists. I agree to notify the program provider if there is any change in the information that I have provided regarding my financial relationships prior to the educational program or publication of my work.

Please sign and date a hard copy of this form, scan it as a PDF, and include it with the application; or type your first and last names in space below and submit the form via email to [CE-Program@UCHealth.com](mailto:CE-Program@UCHealth.com). Receipt of this form via an individual’s email account will act as an electronic signature for that individual. Receipt of this form from an email account other than the person named above CANNOT be considered an electronic signature for that individual.

|  |  |
| --- | --- |
|  |  |

Signature Date

# UCHealth

# CE ACTIVITY APPROVAL FORM

**Title of Offering: Hip Fractures: What the RN Needs to Know**

**SAMPLE of Outline**

**Date(s) of Offering: 1/26/2015**

**PROGRAM #\_\_1NSCE842\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Outcome:**  List the outcome (s) in operational/behavioral terms using measurable verbs from the following page**.(Example: State the rules of delegation according to OAC 4723-13)** | **Content (topics):**  **Provide a detailed outline of the content** to be presented for each objective. | **Time Frame:**  State the time frame for the topic area, including breaks | **Faculty:**   * List the faculty or presenter for each topic * Include faculty/participant ratio. | **Teaching Method:**  Describe the teaching method(s) used for each objective. |
| 1. Identify the anatomy of the hip region. | 1. Hip Joint 2. Iliac Crest 3. acetabulum 4. Femur 5. Head 6. Neck 7. greater and lesser trochanter   C. Femoral shaft | 10 minutes | Dr. A. Roth  1:20 | Lecture  Slides  handouts |
| Break |  | 10 minutes |  |  |
| 2. Describe various hip fractures. | 1. Fractures classified by Anatomic Location 2. Femoral Neck 3. Femoral Head 4. Femoral Shaft | 20 minutes | Dr. A. Roth  1:20 | Lecture  Slides  handouts |
| 3. Evaluate various treatment modalities. | 1. Various Surgical Procedures   A. Compression Plates  B. Bipolar Implants  C. Intramedullary Nail | 30 minutes | Angie Arne, MSN, RN  1:20 | Lecture  Slides  handouts |
| 4. Evaluation |  |  |  | questionnaire |



Disclosure Statement: The faculty and planning committee have declared no conflict of interest with this activity.

(Only After CE has been approved)

**Sample of CE Program Advertising**

CONTINUING EDUCATION ATTENDANCE SHEET

**Sample**

**Program Title: Hip Fractures: What the RN Needs to Know Program #: 1NSCE842 .**

**Program Coordinator: Rachel Q. Nurse, MSN, RN Date: 1/26/15 .**

# PLEASE PRINT

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **TITLE \*** | **EMPLOYEE ID#** | **FACILITY / UNIT or HOSPITAL** |
| 1. **Tina Turner** | **RN** | **12345** | **UCMC/4N** |
| 1. John Quincy Adams | STNA | 23456 | UCMC/4N |
| 1. Michael Knight | RN | 34567 | UCMC/8E |
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Print clearly and include EIN. CE credit cannot be confirmed for an individual if we cannot read the name and EIN. **\* Must clearly indicate RNs vs *not* for correct totaling of Contact hours.**

**PROGRAM EVALUATION**

**Sample**

**UC HEALTH**

**CONTINUING EDUCATION**

**TITLE: Hip Fractures: What the RN Needs to Know Program #: 1NSCE842**

**PROVIDER UNIT COORDINATOR: Amy Costanzo MSN, RN-BC Date: 1/26/15**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **EXCELLENT** | **GOOD** | **POOR** |
| 1. Did this educational activity meet your personal and professional needs?  Comments: | 3 | 2 | 1 |
| 2. Will the content gained in the CE Activity be useful in your practice?  Comments: | 3 | 2 | 1 |
| 3. Was the faculty effective in:  (Each speaker must be listed: A,1,2; B,1,2; C,1,2; etc.)  A. Dr. A. Roth   1. Knowledge of Subject 2. Method of Presentation (PowerPoints, lecture, activities etc.)   3. Instructor answered the questions effectively  B. Angie Arne, MSN, RN   1. Knowledge of Subject 2. Method of Presentation (PowerPoints, lecture, activities etc.)   3. Instructor answered the questions effectively | 3  3  3  3 | 2  2  2  2 | 1  1  1  1 |
| 4. Did the content meet the following objectives: |  |  |  |
| A. Identify the anatomy of the hip region | 3 | 2 | 1 |
| C. Describe various hip fractures | 3 | 2 | 1 |
| D. Evaluate various treatment modalities | 3 | 2 | 1 |
|  |  |  |  |
| 5. Was this educational activity free of commercial bias? | yes |  | no |
|  |  |  |  |
| 6. Will content learned change your clinical practice | yes |  | no |

7. Comment on what you would do differently in your practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments/Suggestions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **An individual and separate FINANCIAL DISCLOSURE form must be completed by every planning committee member and presenter.** |

# UC Health CE Approver Unit

**Sample**

# Financial Disclosure Form

**In accordance with the UC Health Position on Commercial Support and UC Health and Ohio Board of Nursing standards, all planners, speakers, and authors involved in the development of continuing education (CE) content are required to disclose to the program provider their relevant financial relationships. An individual has a relevant financial relationship if he or she has a financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the CE activity content over which the individual has control. Relevant financial relationships will be disclosed to the activity audience.**

|  |  |
| --- | --- |
| Conference/Program Title: | **Hip Fractures: What the RN Needs to Know** |
| Planner/Presenter/Content Expert Name: | **Rachel Q. Nurse, MSN, RN** |

1. Does the CE content over which you have control contain information about healthcare products or services?

|  |
| --- |
| Yes  No (Answer is required.) |

If Yes, please move to question 2. If No, please sign a hard copy. If submitting electronically, type your name in the signature line at the bottom of this form and email to [CE-Program@UCHealth.com](mailto:CE-Program@UCHealth.com).

1. Regarding the healthcare products or services that will be discussed in the CE content over which you have control, have you had a financial relationship in any amount in the last 12 months with companies that produce these products or provide these services?

|  |
| --- |
| Yes  No (If Question 1 is Yes, you must answer Question 2.) |

If Yes, please complete the table below. If No, please sign a hard copy, or if submitting electronically type your name in the signature box at the bottom of this form.

If Question 2 is “Yes”, you must list at least one relationship in the table.

|  |  |  |  |
| --- | --- | --- | --- |
| Company or Service Provider | Nature of Relationship (e.g., independent contractor, employee, consultant, advisory board, research grant recipient [exceptions: non-profit or governmental organization, and non-healthcare related companies] non-CE speakers bureau, stockholder, etc. | Are you continuing to receive a financial benefit from this relationship? | If the relationship has ended, when?  MM/DD/YYYY |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |

Signature

I confirm that the information reported above is accurate. I understand that this information will be disclosed publicly in conference materials or publications, where appropriate. I further understand that the program provider reserves the right to replace me in an educational program, decline to publish my work, or otherwise limit my participation in this particular activity if they believe that a significant conflict of interest exists. I agree to notify the program provider if there is any change in the information that I have provided regarding my financial relationships prior to the educational program or publication of my work.

Please sign and date a hard copy of this form, scan it as a PDF, and include it with the application; or type your first and last names in space below and submit the form via email to [CE-Program@UCHealth.com](mailto:CE-Program@UCHealth.com). Receipt of this form via an individual’s email account will act as an electronic signature for that individual. Receipt of this form from an email account other than the person named above CANNOT be considered an electronic signature for that individual.

|  |  |
| --- | --- |
| *Rachel Q. Nurse, MSN, RN* | *12/1/2014* |

Signature Date

Verb List For Writing Educational Objectives

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **KNOWLEDGE** | | | **COMPREHENSION** | | |
| cite | recite | associate | express |
| count | recognize | clarify | extrapolate |
| define | record | compare | interpolate |
| draw | relate | compute | locate |
| identify | repeat | contrast | predict |
| indicate | select | describe | report |
| list | state | differentiate | restate |
| name | tabulate | discuss | revise |
| point | tell | distinguish | translate |
| quote | trace | explain |  |
| read | write | estimate |  |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **APPLICATION** | | **ANALYSIS** | | |
| apply | predict | analyze | distinguish |
| calculate | practice | appraise | experiment |
| complete | relate | contract | Infer |
| demonstrate | report | criticize | inspect |
| dramatize | restate | debate | inventory |
| employ | review | detect | question |
| examine | schedule | diagram | separate |
| illustrate | sketch | differentiate | summarize |
| interpret | solve |  |  |
| interpolate | translate |  |  |
| locate | use |  |  |
| operate | utilize |  |  |
| order |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **KNOWLEDGE** | | **COMPREHENSION** | | |
| arrange | integrate | appraise | measure |
| assemble | manage | assess | rank |
| collect | organize | choose | rate |
| compose | plan | critique | recommend |
| construct | prepare | determine | revise |
| create | prescribe | estimate | score |
| design | produce | evaluate | select |
| detect | propose | grade | test |
| formulate | specify | judge |  |
| generalize |  |  |  |