



NURSES CONTINUING EDUCATION APPLICATION

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<u>Applicant Name and Address:</u>	<u>Telephone Number (Including Area Code):</u>
	<u>Email:</u>

Application Submitted for: Presentation Request CE for: RN Category A
 Independent Study (Check each that apply) LPN

Title should be clear and succinct and should reflect content of program.

Title of Presentation/Independent Study:	
First Date to be offered:	Advertising information: (where will the presentation be advertised?) Ads must include a person to contact re: OBN CE approval status)- attach a copy of advertising material/brochure

Documentation of need describing how this education will improve the practice of the RN/LPN and relevance to persons with DD:

Total Classroom Contact Hours is the number of hours of presentation which includes explanation/discussion of outcomes, pre and/or post-tests and evaluation of the presentation. Break times are not included. Total minutes divided by 60 = contact hours.

Total OBN CE Contact Hours requested: Number of contact hours included in total that are category "A":

DISCLOSURES:

#1 The primary purpose for this CE activity is to promote the sale of items or services No Yes **If Yes Explain:**

#2 If any commercial support or sponsorship support is provided for an educational activity, the CE provider will maintain control of the educational content and disclose to attendees all financial relationships, or lack of any financial relationships, between the commercial supporter or sponsor and the CE provider or presenter. In addition, the provider will ensure that arrangements for commercial exhibits will not influence the planning of, or interfere with the presentation of, educational activities. Agree Disagree

#3 Presenter(s) declares vested interested: No Yes **If Yes Explain:**

*The Presenter(s)/Faculty must notify the audience of the status of any vested interest as being none or if so, what that interest is.

YOU MUST SUBMIT A SUMMARY OF THE EVALUATIONS AND THE ATTENDANCE SHEET(S) TO THE INTAKE NURSE WITHIN 6 WEEKS OF THE PRESENTATION

FOR CE INTAKE NURSE USE ONLY

Date Application Received:		Application Number:	
Approved for: (Check all that apply)	<input type="checkbox"/>	Registered Nurse	Outcome of Review:
	<input type="checkbox"/>	Licensed Practical Nurse	<input type="checkbox"/> Approved
			<input type="checkbox"/> Denied
			<input type="checkbox"/> Pending

If Application is denied or pending, give rationale:

_____ _____
Intake Nurse's Signature Date

Attendance verification sheets, and Summary of evaluations received by Intake Nurse:

Date: _____ Signature _____