**Individual Educational Activity Application**

* **Always** download new application materials to ensure you have the most current versions. Do not use saved file copies of this application as items may change to maintain compliance with our accrediting bodies.
* Applications must be received by 45 business days prior to the activity date. ADCES will return applications received less than 35 business days prior to the activity’s initial date as we are unable to process applications that quickly.
* Changes after an activity has been approved must be reviewed and approved by ADCES **prior** to changes being made. In some cases, changes may require a new CE Application, an additional review, and/or incur a fee for the requested changes. For change requests, please email ADCES to discuss options.

Applicants interested in submitting an educational activity for approval must first complete the following:

 [ ]  Individual Educational Activity Applicant Eligibility Verification Form,

 [ ]  Individual Activity Applicant Eligibility Commercial Interest Addendum (if applicable)

**Has the application been received and denied by another accrediting body?**

[ ]  No [ ]  Yes (If **yes**, please describe the circumstances and resolutions in a cover letter and attach to application):

**Is this continuing education?** Is this learning activity intended to build upon the educational and experiential bases of the professional Nurse and Pharmacist for the enhancement of practice, education, administration, research, or theory development, to improve the health of the public and Nurses’ and Pharmacists’ pursuit of their professional career goals?

[ ]  No (If **no**, this activity is **not** eligible for approval) [ ]  Yes

1. **Organization name:**
2. **Applicant category:** Choose an item (dropdown).
3. **Contact information for this activity:**

Name and credentials: Click here to enter text.

Email Address: Click here to enter text.

Will this activity be co-provided with another group? [ ]  No [ ]  Yes:

1. **Title of Overall Activity:** Click here to enter text.
2. **Date of Activity:** Click here to enter a date.
3. **Location of Activity (city and state):** Click here to enter text.
4. **Continuing education credit is being sought for (check all that apply):**
[ ]  Pharmacists (ACPE) [ ]  Nurses (ANCC) [ ]  [CDE/CDCES](https://www.ncbde.org/currently_certified/recognized-provider-list/)
5. **Activity Type A – Select the activity type that applies to this program:**

 [ ]  Live: in person or webinar (Provider-directed, provider-paced)

Contact hour calculation: Total minutes of activity:       Divided by 60 mins =       (Total hours)

 [ ]  Enduring material: Provider-directed, learner-paced

* Start date of enduring material: Click here to enter a date.
* Expiration/end date of enduring material: Click here to enter a date.

Contact hour calculation: Total minutes of activity:       Divided by 60 mins =       (Total hours)

|  |
| --- |
| If this activity is Enduring, what was the method for calculating contact hours? |
| [ ]  Pilot Study data:       | [ ]  Historical Data:       |
| [ ]  Complexity of content and data:       | [ ] Other:       |

1. **Description of the target audience:** (You can select more than one target audience)

[ ]  All RNs [ ]  Advanced Practice RNs [ ]  LNPs [ ]  RNs in specialty areas:
[ ]  All Pharmacists [ ]  PharmD [ ]  RPh
[ ]  CDEs [ ]  Other:

1. **Does this activity qualify as** [**interprofessional continuing education (IPCE)**](https://drive.google.com/file/d/1R1_uwWaQMLZQB_wEc5vv6Ggvzr2BDPU8/view)**?** (If all items in the list below apply to your activity, then the answer is yes)
▪ The target audience includes more than one profession
▪ The activity was planned with representation from all professions listed in your target audience
▪ The activity was intentionally designed to identify an educational gap in the current state of the health care team so that the team may learn about and/or from one another
[ ]  No [ ]  Yes - If yes, please indicate how this activity will impact the interprofessional team:
2. **Planning Committee Representatives:** For each profession selected as your target audience, a planner of that same profession must be included as part of the planning committee to be considered interprofessional continuing education (IPCE). Otherwise, only a Nurse Planner is required.

11a. **Nurse Planner contact information for this activity** (Always required)

Name and credentials: Click here to enter text.

Email Address: Click here to enter text.
 RN License #: Click here to enter text.

The **Nurse Planner** must be a registered nurse who holds a current, unencumbered nursing license (or international equivalent) **AND** hold a baccalaureate degree or higher in nursing (or international equivalent) **AND** be actively involved in planning, implementing and evaluating this continuing education activity. **If the Nurse Planner has an actual or potential conflict of interest, he or she must recuse himself or herself from the role as Nurse Planner for the educational activity.**

11b. **Pharmacist Planner:** Required for IPCE if Pharmacists are included in target audience.

Name and credentials: Click here to enter text.

Email Address: Click here to enter text.

[ ]  Not applicable

11c. **Other Professional Planner:** Required for IPCE if other professions are included in target audience.

Name and credentials: Click here to enter text.

Email Address: Click here to enter text.

[ ]  Not applicable

If there are additional planners representing your target audience, attach a separate sheet with their name, email, and which designation they are representing

1. **Activity Type B** *(Pharmacist credit only)* as defined by the Accreditation Council on Pharmacy Education, ACPE). **Please check only one box**:

[ ]  **Knowledge-based** (minimum 15 min or .25 contact hour) program designed primarily for participants to acquire factual knowledge.
[ ]  **Application-based** (minimum 60 min or 1 contact hour)program designed primarily for participants to apply information learned in the allotted timeframe of the program.
[ ]  [**Certificate Program**](https://drive.google.com/open?id=1Q4TtRo2VoTAj3N_amXBUmUwkpl8VoXaA) (minimum of 15 hours) program constructed to instill, expand, or enhance practice competencies through the systematic achievement of specified knowledge, skills, attitudes, and performance behaviors. Click link for more information.

1. **Provide a brief description of the activity/program (100 words or less):**
2. **Description of the professional practice gap (e.g. change in practice, problem in practice, opportunity for improvement)** [**Click here for examples**](https://drive.google.com/file/d/1WmrGh74iXNvRrBPb3ZeTqbsPyOl5Q91q/view)

Describe the current state:

Describe the desired state:

Identified gap:

1. **Evidence to validate the professional practice gap above (check all that apply):**

[ ]  Surveyed data from stakeholders, target audience members, subject matter experts or similar

[ ]  Received input from stakeholders such as learners, managers, or subject matter experts

[ ]  Gathered evidence from quality studies and/or performance improvement activities to identify opportunities for improvement

[ ]  Analyzed evaluation data from previous education activities

[ ]  Identified trends in literature, law and health care

[ ]  Found practice gap(s) during direct observation in our practice

[ ]  Other—Describe:

1. **Educational need that underlies the professional practice gap (e.g. knowledge, skill and/or practices)**

[ ]  Gap in knowledge (knows) [ ]  Gap in skills (knows how)

[ ]  Gap in practice (shows/does) [ ]  Other- Describe:

**State the educational need that you determined to be the cause of the professional practice gap(s) above:**

1. **Desired learning outcome(s) *(To be written in measurable terms)*** [**Click here for examples**](https://drive.google.com/file/d/1WmrGh74iXNvRrBPb3ZeTqbsPyOl5Q91q/view)
2. **Please select short-term and long-term evaluation options to measure if learning outcomes were met:**

**Short-term evaluation options (during or immediately after the activity):**

[ ]  Intent to change practice stated on the evaluation form [ ]  Successful return demonstration documented

[ ]  Posttest completion during/immediately after activity [ ]  Analyze/determine appropriate action for case studies

[ ]  Participation in role-play [ ]  Observation of active participation in learning activity [ ]  Other – Describe:

**Long-term evaluation options (anytime you choose to measure the effectiveness after the activity):**

[ ]  Self-reported change in practice on follow-up evaluation [ ]  Report observations of changes in performance

[ ]  Discuss changes in quality outcome measure to evaluate effectiveness of the implemented change in practice

[ ]  Assess return on investment of the change in practice [ ]  Other – Describe:

1. **Criteria for Awarding Contact Hours**

Criteria for awarding contact hours for live and enduring material activities include:

(Check all that apply)

[ ]  Attend 100% of activity, or miss no more than 10 minutes of activity

[ ]  Completion/submission of evaluation form

[ ]  Successful completion of a post-test (e.g., attendee must score      % or higher)

[ ]  Partial credit will be available for this program. Please describe breakdown:

1. **Individuals in a Position to Control Content**

Complete the table below for each person in a position to control content of the educational activity and include name, credentials, educational degree(s), role on the planning committee, and expertise that substantiates their role. There must be one Nurse Planner and one other planner to plan each educational activity. The Nurse Planner is knowledgeable of the CNE process and is responsible for adherence to the ANCC criteria. One planner needs to have appropriate subject matter expertise for the educational activity being offered (Content Expert). **All individuals involved in the planning and implementation of this activity must be identified; Nurse Planner, content experts, presenters, etc.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of individual and credentials** | **Individual’s role in activity** | **Planning committee member?** | **Name of commercial interest** | **Nature of relationship** |
| *Example: Jane Smith, RN-BC* | *Nurse Planner* | *Yes* | *None* | *---* |
| *Example: Sue Brown, RNC* | *Content Expert* | *Yes* | *None* | *---* |
| *Example: John Doe, PhD* | *Presenter* | *No* | *Pfizer* | *Speakers Bureau*  |
|       |  Choose an item.  |       |       |       |
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**(If there are additional individuals involved in the planning and implementation of this activity, please attach a separate page using the same column headings).**

1. **Evaluation of Conflict of Interest:**
During review of the conflict of interest forms, were there any potential conflict of interest relationships identified?

[ ]  No [ ]  Yes

If yes, what was the concern and what was done to resolve it?

**Attachments Checklist**

Prior approval materials – please provide evidence of the following:

|  |  |
| --- | --- |
| **Attachment 1** | [ ]  [Biographical data/Conflict of Interest](https://drive.google.com/open?id=14SXo2SAIf0nZ2sUEu87QM3nuk_dUaeoe) form for **all individuals** involved in planning, implementing and in a position to control content for this activity and resolution. |
| **Attachment 2** | [ ]  [Educational Planning Table(s)](https://drive.google.com/open?id=130yUFhR_UDtuNGF8i5lb6Qgs3JlH4Y9p) for the activity |
| **Attachment 3** | [ ]  [Marketing/Promotional material](https://drive.google.com/open?id=1XPZ3O0Wnt5p1iDzJjxClorMJJm6Ncz2V) including an agenda for the activity (cannot distribute, post or market activity without prior approval) |
| **Attachment 4** | [ ]  [Activity evaluation form](https://drive.google.com/open?id=1MsE4an2B1q88ic3FPvKweomFfKWGhVkS) and[ ]  Pre and/or Post-test (if applicable) |
| **Attachment 5** | [ ] Program handouts/PowerPoint slides (to be submitted 15-30 days prior to program date) |
| **Attachment 6 (if applicable)** | Will there be a Joint-Provider for the program? [ ]  No [ ]  Yes [ ]  [Joint-Provider Agreement](https://drive.google.com/open?id=1TIkhP8sVn38Jm0iHZliKEAj9F4RQ6EaE) with signature date (required if Joint-Provider) |
| **Attachment 7 (if applicable)** | Will there be Commercial Support for the program? [ ]  No [ ]  YesWill there be Sponsorship for the program? [ ]  No [ ]  YesIf yes to either of these, please provide the source of commercial support and type of support: Source:       [ ]  In-Kind support – Describe:       [ ]  Monetary - $       [ ]  [Commercial Support Agreement](https://drive.google.com/open?id=1XG-5VtVMl5T6aKB4WaXTGW5Z65RcF9Ic) with signature and date (required if Commercial Support)[ ]  [Sponsorship Agreement](https://drive.google.com/open?id=1XHsRB67ZtJSaevuBhldsDUQVXd_Xp-Du) with signature and date (required if Sponsorship) |
|  | [ ]  By checking this box, I agree to allow ADCES to use my organization’s name in marketing and promotional materials |

**Post Activity Materials are to be submitted to ADCES no later than 30 days past activity date and include the following:**

* FINAL copies of handouts/PowerPoint slides that were distributed to attendees at program including disclosure slide
* Completed sign-in sheets per discipline verifying participants attendance in the program
* Completed Summative Evaluation with Nurse Planner’s review of the Summative Activity Evaluation Report to assess the activity’s effectiveness and to identify how results will be used to guide future educational activities.
* One copy of final program advertising brochure or other marketing literature with final accreditation statement and logo
* Documentation of completion and/or certificate (attach template)

**Failure to submit post materials on time will result in a weekly fee until program materials are received.**

**Record-keeping materials
to be confidentially stored for up to seven (7) years from program date**

|  |  |
| --- | --- |
|  | [ ]  I agree to retain a copy of this application and keep the required program records on file for seven (7) years from the program date  |
|  | Please provide name, title, address, location and secure method for which storage of records for this program will be kept for retrieval:  Click here to enter text. |

**Completed by:**       **Date:**

***For ADCES use only***

**Date Received:**