**Individual Educational Activity Application**

Guidelines for submitting an 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. AADE will return applications received less than 30 business days prior to the activity’s initial date as we are unable to process applications that quickly
* Changes after an activity has already been approved must be reviewed and approved by AADE **prior** to changes being made. In some cases, changes may require a new CE Application, and additional review, and/or incur a fee for the requested program change. For change requests, please email AADE to discuss options.

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

Individual Educational Activity Applicant Eligibility Verification Form,

Individual Activity Applicant Eligibility Commercial Interest Addendum (if applicable),

1. Applicant's Name:
2. Applicant category: Choose an item (dropdown).
3. Applicant 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. 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):

1. Continuing education credit is being sought for (check all that are requested):

Pharmacists (ACPE)  Nurses (ANCC)  CDEs

1. 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. Title of 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. Activity Type-A:

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

* Live activity contact hour calculation:

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| --- | --- | --- |
| Total minutes of activity CE: | Divided by 60 minutes = | Total amount of CE’s for activity: |

Provider-directed, learner-paced: Enduring material

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

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| Total minutes of activity CE: | Divided by 60 minutes = | | Total amount of CE’s for activity: |
| What was the method for calculating contact hours? | | | |
| Pilot Study data: | | Historical Data: | |
| Complexity of content and data: | | Other: | |
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Blended activity

* Date(s) of enduring materials (e.g. prework): Click here to enter a date.
* Date of live portion of activity: Click here to enter a date.

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| Total minutes of activity CE: | Divided by 60 minutes = | | Total amount of CE’s for activity: |
| Enduring only: 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  
 CDR Credentialed Practitioners  
 CDEs  Other:

1. 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).**  
   Does this activity qualify as interprofessional continuing education (IPCE)? No  Yes

12a.Nurse Planner contact information for this activity. **(Always required)**

Name and credentials: Click here to enter text.

Email Address: 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.**

12b. 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

12c. RD Planner: Required for IPCE if Dietitians are included in target audience.

Name and credentials: Click here to enter text.

Email Address: Click here to enter text.

Not applicable

12d. 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

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 primary 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.  
 **Practice-based** (minimum of 15 hours) program designed to systematically acquire specific knowledge, skills, attitudes, and performance behaviors that expand or enhance practice competencies.

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)**

Describe the current state: The following are 2 examples of the description of current state:  
a. The care team is responsible for providing diabetes self-management education including topics relevant to insulin pump use.

b. The care team responsible for providing motivation and assisting with goal setting with people with diabetes.

       
  
Describe the desired state: The following are 2 examples of the description of desired state:  
a. The care team will have increased knowledge about advanced insulin pump features to better meet the challenges of daily diabetes management.

b. The care team will have increased confidence and ability to effectively conduct motivational interviewing and goal setting with people with diabetes.

       
  
Identified gap: The following are 2 examples of Identified Gap(s):  
a. Insulin pumps are becoming more common for treatment of type 1 diabetes as an alternative to multiple daily injections. The care team needs advanced knowledge about insulin pump management.

b. The care team needs familiarity with motivational interviewing and goal setting skills to facilitate behavior change in people with diabetes.  
  
     

1. **Evidence to validate the professional practice gap (check all methods/types of data that apply)**

Survey data from stakeholders, target audience members, subject matter experts or similar

Input from stakeholders such as learners, managers, or subject matter experts

Evidence from quality studies and/or performance improvement activities to identify opportunities for improvement

Evaluation data from previous education activities

Trends in literature, law and health care

Direct observation

Other—Describe:      

**Provide a brief summary that validates the need for this activity:** The following are 2 **examples**:  
a. Previous program evaluations completed by diabetes educators identified that insulin pump therapy is an area where they feel the care team can acquire more information and education to effectively help type 1 and type 2 patients with insulin pumps.

b. During our Planning Committee meeting it was discussed that insulin pump therapy is an area where they feel the care team an acquire more information and education to effectively help type 1 and type 2 patients with insulin pumps.

     

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:

1. **Area of Impact (check all that apply):**

Nursing Professional Development  Dietitian Professional Development  Pharmacist Professional Development  Patient Outcome  Other- Describe:        
**For IPCE: If more than one profession was selected, please indicate how this activity will impact the interprofessional team:**

1. **Desired learning outcome(s) *(What will the outcome be as a result of participation in this activity?)* (information on how to write a learning outcome can be found here** [**Writing Learning Outcomes**](https://drive.google.com/file/d/0B7jWJNpGumCpUWc2ZWhiRjRDWDg/view?usp=sharing)**)**The following are 2 **examples** of an outcome statement:  
   a. The team will become more knowledgeable about advanced insulin pump features to better meet the challenges of daily diabetes management  
   b. The team will be able to effectively facilitate behavior change through use of motivational interviewing and goal setting strategies
2. **Outcome Measure(s) (A quantitative statement as to how the outcome will be measured):  
   Example:** The outcome will be measured via case study analysis and evaluation which includes a question on intent to change practice.

     

**AADE7TM Self Care Behaviors – Select from the AADE7TM Self Care Behavior area(s) this activity will address**

Healthy Eating  Being Active  Monitoring

Taking Medication  Problem Solving  Healthy Coping  Reducing Risks

1. **Criteria for Awarding Contact Hours**

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

(Check all that apply)

Attendance for a specified period of time (e.g., 100% of activity, or miss no more than 10 minutes of activity)

Credit awarded commensurate with participation

Attendance at 1 or more sessions

Completion/submission of evaluation form

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

Successful completion of a return demonstration

Other - Describe:

Partial credit will be available for this program. Please describe breakout for partial credit:

1. **Description of evaluation method: Evidence that change in knowledge, skills and/or practices of target audience was assessed**

**Short-term evaluation options:**

Intent to change practice  Active participation in learning activity  Post-test

Return demonstration  Case study analysis  Role-play  Other – Describe:

**Long-term evaluation options:**

Self-reported change in practice  Change in quality outcome measure

Return on Investment (ROI)  Observation of performance  Other – Describe:

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.**

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| **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* |
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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?

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| **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 (if applicable). |
| **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 with signature date (required if Joint-Provider) |
| **Attachment 7 (if applicable)** | Will there be Commercial Support for the program?  No  Yes  Will there be Sponsorship for the program?  No  Yes  If 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) |

**Attachments Checklist**Prior-Approval materials - Please provide evidence of the following:

**Post Activity Materials  
to be submitted to AADE no later than 30 days past activity date**

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| **Attachment 1** | FINAL copies of handouts/PowerPoint slides that were distributed to attendees at program including disclosure slide |
| **Attachment 2** | Completed sign-in sheets per discipline verifying participants attendance in the program |
| **Attachment 3** | 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. |
| **Attachment 4** | One copy of final program advertising brochure or other marketing literature with final accreditation statement and logo |
| **Attachment 5** | Documentation of completion and/or certificate (attach template) |

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

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|  | 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 AADE use only***

**Date Received:**