

**ALABAMA BOARD OF NURSING
CONTINUED Approval Continuing Education Application**

NOTE: Non-refundable fee of \$400 must accompany the completed application

PART A: DEMOGRAPHIC INFORMATION

1. Provider/Business Name:		2. Phone Number including area code:				
3. Physical Address:	City:	State:	Zip Code:			
4. Mailing Address: (If different)	City:	State:	Zip Code:			
5. Provider Number	6. County					
7. Provider's web site address:	8. Number of continuing education activities you provided over the past four (4) years_____					
<p>9. Provider is :(Mark one of the options below or if none apply specify under other.)</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Clinic <input type="checkbox"/> College/University/School <input type="checkbox"/> Hospice/Home Health Care <input type="checkbox"/> Hospital/Medical Center/Medical System <input type="checkbox"/> Mental Health Service <input type="checkbox"/> Nursing and Rehabilitation Center (Nursing home) <input type="checkbox"/> Rehabilitation Center </td> <td style="width:50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Outpatient Service <input type="checkbox"/> Public Health Agency <input type="checkbox"/> Publication <input type="checkbox"/> Regional/National Association <input type="checkbox"/> Regulatory Agency <input type="checkbox"/> Self Employed Provider <input type="checkbox"/> State Association <input type="checkbox"/> Other _____ </td> </tr> </table>					<input type="checkbox"/> Clinic <input type="checkbox"/> College/University/School <input type="checkbox"/> Hospice/Home Health Care <input type="checkbox"/> Hospital/Medical Center/Medical System <input type="checkbox"/> Mental Health Service <input type="checkbox"/> Nursing and Rehabilitation Center (Nursing home) <input type="checkbox"/> Rehabilitation Center	<input type="checkbox"/> Outpatient Service <input type="checkbox"/> Public Health Agency <input type="checkbox"/> Publication <input type="checkbox"/> Regional/National Association <input type="checkbox"/> Regulatory Agency <input type="checkbox"/> Self Employed Provider <input type="checkbox"/> State Association <input type="checkbox"/> Other _____
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10. PROGRAM DIRECTOR: (Contact person responsible for the provider number & approving programs.)	
Name: _____	Phone No: () _____ - _____
Physical Address (if different from above): _____	
Nursing License Number (if applicable): _____	
E-mail Address: _____	Fax No: _____

11. REGISTERED NURSE CONSULTANT: (If program director is NOT a registered nurse with an Alabama Nursing License)

Name: _____ Phone No: _____

Physical Address: _____

ALABAMA Nursing License Number: _____

E-mail Address: _____ Fax No: _____

12. INDIVIDUAL RESPONSIBLE FOR RECORD KEEPING: (Complete if different from contact person.)

Name: _____ Phone No: _____

Physical Address (if different from above): _____

E-mail Address: _____ Fax No: _____

13. ADMINISTRATOR OF FACILITY/AGENCY/COMPANY

Name: _____ Phone No: _____

Physical Address (if different from above): _____

E-mail Address: _____ Fax No: _____

14. TRICORDER (TriComm data Reader)

Physical Location: _____

Your Computer Operating System XP Vista Windows 7

Other, please specify _____

Part B: ORGANIZATION AND ADMINISTRATION

1. Submit the **mission statement of your agency's education unit** regarding continuing education [ABN Administrative Code Rule 610-X-10-.06 (1) (b)].

2. List the **education UNIT's objectives** regarding continuing education [ABN Administrative Code Rule 610-X-10-.06 (1) (b)] and indicate how each objective will be evaluated, the time frame of the evaluation process and the person responsible for the evaluation. Example forms are available under the ABN website CE tab then select CE forms.

3. Provide a **written description of your agency's organizational structure** with details of where the education unit is located within the organizational structure. [ABN Administrative Code Rule 610-X-10-.06 (1) (d)]
4. List the **roles and responsibilities of the program director** of the educational unit. State what qualifies the director for the position. [ABN Administrative Code Rule 610-X-10-.06 (2) (b)]
5. If the program director is not a registered nurse provide evidence of consultation by an RN to facilitate planning, development and evaluation of continuing education in nursing. Include names of individual, license number and the state in which they are licensed [ABN Administrative Code Rule 610-X-10-.06 (2) (b)(i)].

Part C: POLICIES AND PROCEDURES FOR IMPLEMENTATION AND EVALUATION OF THE EDUCATIONAL PROGRAMS [Chapter 610-X-10-.06(1)(c)]

1. **Attach copies of the following policies & procedures** (simple one or two sentence answers are not appropriate policies and procedures)
 - a. Process for assessing and planning for continuing education for nurses including how it is determined that a class/program is needed, and the participants in the assessment and planning process.
 - b. Approval process for approving Continuing Education courses/classes/programs including what documents are sent in to get a class approved and who reviews these documents and gives approval for the course(s).
 - c. Selection of instructors and verification of instructor competence to present the CE activities including who selects faculty for courses and how competency to present is determined or verified.
 - d. Advertising guidelines including how potential participants will be made aware of the program(s), including potential participants that are non-employees and the inclusion of the ABN Provider number & expiration date [ABN Administrative Code Rule 610-X-10-.06(4)(a)]
 - e. Fee assessment, Refund guidelines including the charging of any fees for employees and non-employees, collection of fees and refunds.

- f. Awarding of contact hours or credit including the unit used to award contact hours, any requirement for card swiping, certificates (if applicable) and participants arriving late or leaving early.
- g. Electronic submission of records to the ABN including time frame for submitting to ABN after the class completion and person responsible.
- h. Evaluation of classes, courses, programs offered for CE for nurses including document used by participants to evaluate class, person responsible for tallying results and response(s) to any negative comments.
- i. Records and reports maintenance including retention of records, release of records and disposition of records in the event of the demise of the facility/agency/company or retirement of the provider number.

Part D: CONTINUING EDUCATION

Submit **THREE** examples of CE courses developed by your facility/agency/company that were presented during the past 12 months

(Do **NOT** send standardized national courses such as ACLS and BCLS)

For each of the three courses, include the following:

- a) Statement of course title, sponsoring agency (ies), date of presentation(s).
- b) Statement of need for the course.
- c) Written statement of intended learning outcome (measurable behavioral/performance objectives).
- d) Outline of content, time frame for each topic and instructional methodology. (Sample outline attached.)
- e) Evaluation process for determining degree to which learner objectives are met, instructor proficiency and effectiveness and management of course.
- f) Instructor(s) qualifications to present the course.
- g) Number of contact hours.
- h) Requirements for satisfactory course completion.

i) Summarize participant's evaluation. (Please do NOT send copies of participants' evaluation forms)

Please mail this completed application to the Alabama Board of Nursing with the **\$400.00** non-refundable fee to the following address:

ALABAMA BOARD OF NURSING
State of Alabama
P. O. Box 303900
Montgomery, Alabama 36130

NOTE: Additional forms that may be helpful to you as you plan continuing education activities are located under the CE tab then select CE forms.