

LOUISIANA STATE BOARD OF NURSING

17373 Perkins Road
Baton Rouge, LA 70810
Telephone (225) 755-7500

FOR OFFICE ONLY

Date Rec'd _____

Fee Submitted _____

Approved _____

Term. Date _____

Disapproved _____

LSBN Number _____

APPLICATION FOR CONTINUING EDUCATION REAPPROVAL

INSTRUCTIONS FOR COMPLETION OF FORM:

1. Please provide information in word processing form. Form may be reproduced for word processing.
2. Complete all sections. If space provided is insufficient, please add pages.
3. Identify all attachments with name of provider and item number to which it refers.
4. Submit three (3) paper copies and 1 electronic copy (USB, CD, or DVD; preferably in PDF or Microsoft Office format) of this application for reapproval.
5. Allow at least 60 days for processing the application.

Section I. Identification Data

1. Provider: (The agency, organization, or institution sponsoring the C.E. Program)

Name: _____

Address: _____

Telephone Number: _____

Email Address: _____

2. Contact Person: The designated person who has the overall responsibility for the operation of the Nursing Continuing Education Provider Unit according to regulatory requirements as specified in LAC46:XLVII.3335.G.

Name: _____

Position/Title: _____

Credentials: _____

Academic Degree

License

Business Address: _____

Business Telephone: _____

Relevant Experience for this Role: _____

Section II. Overall Plan of Continuing Education Program

1. Provide the stated philosophy/mission, purpose and goals of the continuing education program: (attach pages as needed.)

2. Is the continuing education program accredited as a provider unit by the American Nurses Association continuing education system (American Nurses Credentialing Center's (ANCC) Commission on Accreditation)?

Yes _____

No _____

If yes, please attach a certified copy of the accreditation document; you do not need to complete the remainder of this application and the fee is waived.

3. Describe the assessment process for determining learning needs of the targeted population and provide a summary of the assessment findings. (Attach pages as needed.)

4. Complete the abbreviated vita form for the Continuing Education Nurse Planner and all members of the planning committee as well as for each speaker/presenter.

5. Attach a copy of the overall program evaluation plan with a summary report of data gathered that provides evaluative information for judging the effectiveness of the program.

Section III. Information Regarding Individual Offerings

1. Submit the program plan or brochure for three of the educational offerings planned and provided by your organization since last approved as a provider.

2. Attach a copy of the evaluation tool used for each offering submitted as well as a summary of the evaluation data for each of the three offerings.

3. Indicate which of the following information is routinely preserved for each offering:

<u>Yes</u>	<u>No</u>	
_____	_____	a. Title of offering
_____	_____	b. Names and addresses of participants and number of contact hours awarded to each
_____	_____	c. Name and titles of all committee members
_____	_____	d. Vita for each presenter (Use attached vita form)
_____	_____	e. Starting and ending dates
_____	_____	f. Name and address of facility where offering was held
_____	_____	g. Program plan as specified in §3335.G.4
_____	_____	h. Description of target audience
_____	_____	i. Number of contact hours awarded for each offering
_____	_____	j. Summary of participants' evaluation
_____	_____	k. Copy of any co-provider agreement, if applicable
_____	_____	l. Copy of certificate awarded that includes: name, location, LSBN provider number, name of organization

4. Enclosure Checklist. Please enclose a copy of each of the following:

- ___ Philosophy and/or mission, purpose, and goals of the CE program
- ___ Description of the needs assessment process with summary of findings
- ___ Brochure/advertisement flyer for 3 programs offered
- ___ Vitae (planning committee and presenters for 3 programs)
- ___ Agenda for each of the 3 programs (if not clearly delineated in brochure)
- ___ Offering/presentation plan (curriculum spreadsheet)
- ___ Offering evaluation form and summary reports
- ___ Overall program evaluation report
- ___ Copy of certificate awarded
- ___ Copy of co-provider agreement if applicable

Check amount, made payable to the Louisiana State Board of Nursing:

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_____ \$1600 for 4 years

_____ \$ 800 for 2 years

CERTIFICATION OF INFORMATION:

This is to certify that the above information is true and correct, and to the best of my knowledge, the proposed offerings represent continuing education as defined in LAC 46:XLVII.3335.B.

Application completed by: _____

Title: _____

Date: _____

VITA FORM

FACULTY/PRESENTER _____

PLANNING COMMITTEE _____

INSTRUCTIONS: Make as many copies of this form as necessary to provide information required to document adherence to the criteria for accreditation. Information for each person must be placed directly on a copy of this form or on a simile of this form word processed. Do not attach any additional material. Thank you.

Name _____

Home Address _____

Business Address _____

Employer Name/Department

Number and Street

City, State, and Zip Code

Telephone _____

Present Position (Title and Description) _____

Education (include basic academic preparation through highest degree held)

DEGREE	YEAR	INSTITUTION	AREA OF STUDY
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Use the space below to provide a **brief** narrative that illustrates your specific professional experience in the subject matter and that validates your expertise as a speaker. Include certification in a specialty, a sample of presentations and publications, grants, and/or awards.