LOUISIANA STATE BOARD OF NURSING
17373 Perkins Road
Baton Rouge, LA 70810
Telephone (225) 755-7500

APPLICATION FOR CONTINUING EDUCATION REAPPROVAL

INSTRUCTIONS FOR COMPLETION OF APPLICATION:

1. Complete all sections. If space provided is insufficient, please add pages.
2. Identify all attachments with name of provider and item number to which it refers.
3. Submit one electronic copy of this application for reapproval through e-mail to scottt@lsbn.state.la.us.
4. 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 LAC 46: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)? [**Check Yes or No**]

   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. *Please duplicate Section III for each offering.*

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:

YES	NO	
		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 the following: name, location, LSBN provider number, name of organization

Section IV. 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 **[Check one]:**

_____$1600 for 4 years   _____$ 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 ____

<u>INSTRUCTIONS</u>: 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. <u>Do not attach any additional material</u>. Thank you.

Name____

Home Address____

____

____

Business Address____
Employer Name/Department

____
Number and Street

____
City, State, and Zip Code

Telephone____

Present Position (Title and Description):____________________________________

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Education (include basic academic preparation through highest degree held)

DEGREE	YEAR	INSTITUTION	AREA OF STUDY

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.

11/95
Rev.: 5/2/2011;9/7/11; 12/10/2013; 6/10/2015, 3/10/2020