

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

**Application for REINSTATEMENT As A
 Continuing Education Provider**

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. Provider's web site address: | | | | |
| <p>7. 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"/> Home Health Care/Hospice <input type="checkbox"/> Hospital/MedicalCenter/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"/> Home Health Care/Hospice <input type="checkbox"/> Hospital/MedicalCenter/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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| <p>8. Program Director: (Individual responsible for the provider number & approving programs.)</p> <p style="margin-left: 40px;">Name: _____ Phone No: _____</p> <p style="margin-left: 40px;">Physical Address (if different from above): _____</p> <p style="margin-left: 40px;">Nursing License Number (if applicable): _____</p> <p style="margin-left: 40px;">E-mail Address: _____ Fax No: _____</p> | | | | | |

9. Nurse Consultant: (If program director is not a registered nurse)

Name: _____ Phone No: _____

Physical Address (if different from above): _____

Nursing License Number: _____ State of Licensure _____

E-mail Address: _____ Fax No: _____

10. 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: _____

11. Administrator of facility/agency/company

Name: _____ Phone No: _____

Physical Address (if different from above): _____

E-mail Address: _____ Fax No: _____

Part B: ORGANIZATION AND ADMINISTRATION

1. Submit the mission statement of your agency's education unit regarding continuing education [Chapter 610-X-10-.06 (1) (b)].
2. List the education unit's objectives regarding continuing education [Chapter 610-X-10-.06 (1) (b)].
3. Provide a written description of your agency's organizational structure with details of where the education unit is located within the organizational structure. [Chapter 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. [Chapter 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 [Chapter 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

- 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 [610-X-10-.06(2)(d)]

- 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: THE EDUCATIONAL UNIT [Chapter 610-X-10-.06(1)(c)]

1. ATTACH THE EVALUATION PLAN FOR THE EDUCATION UNIT INCLUDING:

- a. **Listing again each objective that you listed under B (2), and indicate how your education unit evaluates the objective.**
- b. What is the time frame for this evaluation process?
- c. Who is the individual(s) responsible for the evaluation plan?

You may use the following table if you wish or submit in format of your choice.

| Objectives as listed under B (2) | Time Frame | Responsible Individual | Evaluation Tool/Methods |
|---|-------------------|-------------------------------|--------------------------------|
| | | | |
| | | | |

Part E. CONTINUING EDUCATION

1. Submit **TWO** examples of outlines for continuing education activities that you plan to present or sponsor during the first six (6) – twelve (12) months of approval.

Include the following:

- (a) Statement of course title, sponsoring agency (ies), date, of presentations(s).
- (b) Statement of need for the course.
- (c) Written statement of intended learning outcome (measurable behavioral/performance objectives).
- (d) Outline of content and instructional methodology.

- (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
2. Submit the evaluation form that you plan to use for evaluation of a course or activity.

Please mail this application to the Alabama Board of Nursing with the **\$500.00** non-refundable fee to the following address:

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

Below are additional forms that may be helpful to you as you plan continuing education activities.

OUTLINE OF COURSE CONTENT FOR CONTINUING EDUCATION

Date(s) of class: _____

Title of Education Activity: _____ Contact Hours: _____

Course is needed because _____

Requirements for satisfactory course completion: _____

| Objectives: Upon completion of this program the participant will be able to: | Content | Time Frame | Faculty | Instructional Methodology |
|---|----------------|-------------------|----------------|----------------------------------|
| | | | | |
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INSTRUCTOR INFORMATION IS BELOW

ALABAMA BOARD OF NURSING Instructor Information

| | |
|--------------|--|
| NAME: | 2a. LICENSE NUMBER (if applicable): |
| | 2b. Date of Expiration: |
| | 2c. Type of License: |

| 3. EDUCATION: | | | | |
|----------------------|-------|--------|---------------------|---------------------|
| College/University | Major | Degree | Area of Preparation | Year Degree Granted |
| | | | | |
| | | | | |
| | | | | |

| 4. EXPERIENCE: (Start with most recent experience) | | | | |
|---|----------|---------------|---------------|-------------|
| Agency | Position | Clinical Area | From Mo/Yr | To Mo/Yr |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| 5. TEACHING EXPERIENCE: (Start with most recent experience) | | | |
|--|-------------|----------|------------|
| Title of Course | Description | Location | Month/Year |
| | | | |
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