**University of Cincinnati, College of Nursing**

**OBN Approver Unit (OBN-011-93)**

**Application**

**Faculty Directed Synchronous Learning CNE Activity**

|  |  |
| --- | --- |
| Title of Offering: |  |
| Date of Offering: |  |
| Sponsor (Facility/Organization): |  |
| Address: |  |
| Contact Person: |  |
| Weekday Phone: |  |

|  |  |
| --- | --- |
| Contact Hours Requested: | *To calculate contact hours, add the number of minutes of actual learning time and divide by 60 (round to the nearest tenth – 1 decimal place)* |
| Category A “Law and Rules” Hours Requested: |  |
| “Advanced Pharmacology” Hours Requested: |  |
| “Human Trafficking” Hours Requested: |  |
| *See the Approver Unit Policy Manual for a description of Category A, Advanced Pharmacology, and Human Trafficking education.* | |

**Educational Design Criteria**

1. **RESOURCES**

1. **Person Administratively Responsible for Offering**

|  |  |
| --- | --- |
| Name |  |
| Current position |  |
| Address |  |
| Weekday phone |  |
| Education |  |
| Professional qualifications |  |

2. **Planning Committee** (Must include 2 RNs, one with a BSN, and 1 LPN if LPNs are included in the target audience which includes audiences specified generically as “nurses”)

|  |  |
| --- | --- |
| Name |  |
| Current position |  |
| Credentials |  |
| Professional qualifications |  |

|  |  |
| --- | --- |
| Name |  |
| Current position |  |
| Credentials |  |
| Professional qualifications |  |

**B. TARGET AUDIENCE AND NEEDS ASSESSMENT**

|  |  |  |
| --- | --- | --- |
|  | **Check those that apply** | **Projected Number of Attendees** |
| RNs |  |  |
| LPNs |  |  |
| Other (specify): |  |  |

|  |  |
| --- | --- |
| Briefly describe what led you to identify a need for and plan this offering: |  |

**C. FACULTY CREDENTIALS**

Complete the following section for each faculty that will be presenting or evaluating learners. Do not send complete resumes, vita, or biographies.

|  |  |
| --- | --- |
| Name |  |
| Current position |  |
| Credentials |  |
| Professional qualifications ***to present the planned content*** |  |

|  |  |
| --- | --- |
| Type your initials to indicate that you attached a signed conflict of interest form for this presenter | **Your initials:** |

|  |  |
| --- | --- |
| Name |  |
| Current position |  |
| Credentials |  |
| Professional qualifications ***to present the planned content*** |  |

|  |  |
| --- | --- |
| Type your initials to indicate that you attached a signed conflict of interest form for this presenter | **Your initials:** |

|  |  |
| --- | --- |
| Name |  |
| Current position |  |
| Credentials |  |
| Professional qualifications ***to present the planned content*** |  |

|  |  |
| --- | --- |
| Type your initials to indicate that you attached a signed conflict of interest form for this presenter | **Your initials:** |

D. **USE OF ADULT LEARNING PRINCIPLES IN PLANNING/IMPLEMENTATION**

Identify adult leaning principles used for planning and implementation of offering.

|  |  |
| --- | --- |
| Examples of adult learning principles are highlighted below. Identify **at least 1** of these principles or provide a different principle. ALSO, describe how the principle was used for this program offering. | |
| **PRINCIPLE** | **DESCRIPTION OF HOW AT LEAST *ONE (1)* PRINCIPLE GUIDED OFFERING** |
| Adults are internally motivated and self-directed |  |
| Adults bring life experiences and knowledge to learning experiences |  |
| Adults are goal-oriented |  |
| Adults are relevancy oriented |  |
| Adults are practical |  |
| Adult learners like to be respected |  |
| Other (specify): |  |

**E. PHYSICAL FACILITIES**

Provide details about the location where the program will be offered.

|  |  |
| --- | --- |
| Name of Facility: |  |
| Address of Facility: |  |
| Description of Facility: |  |
| Is Facility ADA Compliant: |  |

**F. CO-SPONSORSHIP**

|  |  |
| --- | --- |
| This offering will be co-sponsored (Yes or No): |  |
| If Yes, provide name and address of co-sponsor: |  |
| As the approved provider, you agree to maintain responsibility for meeting and maintaining OBN standards. You have provided a copy of the written agreement with the co-sponsor(s) which outlines the above. | **Your initials:** |

**G. EVALUATION**

Describe how the achievement of program outcomes and teaching effectiveness of faculty will be conducted.

|  |  |
| --- | --- |
| Type your initials to indicate that you attached a copy of the evaluation tool(s): | **Your initials:** |
| **Describe how the evaluation tool will *measure* the program outcomes** (e.g., passing score on a posttest; passing certification exam within 6 months; demonstration competence to perform a skill; documents changes in knowledge, attitudes, and/or behaviors) |  |

**H. VERIFICATION OF ATTENDANCE**

|  |  |
| --- | --- |
|  | **Initials** |
| Type your initials to indicate that you attached a copy of the certificate of attendance: |  |
| Type your initials to indicate that the certificate includes the following information:   1. Space for name of attendee 2. Title of the program 3. Date of the program 4. Name and address of the provider (your organization) 5. Number of contact hours earned 6. A complete list of the learning outcomes |  |
| Type your initials to indicate that the following statement appears on the certificate of attendance:  *This offering has been approved by the Ohio Board of Nursing through the OBN Approver Unit at the University of Cincinnati College of Nursing (OBN-011-93).* |  |

**I. RECORD KEEPING SYSTEM**

|  |  |
| --- | --- |
| As a provider, you agree to retain records in a retrievable file, which is safe, secure, and accessible to only authorized personnel, for six years. Type your initials for each section to indicate that you will retain records, as described. | **Initials** |
| 1. A complete copy of all application data |  |
| 1. All correspondence with the UC College of Nursing |  |
| 1. A list of all attendees who were awarded contact hours for each date of the CNE offering that includes the number of contact hours awarded |  |
| 1. An evaluation summary for each date of the offering |  |
| 1. Any changes made to the program during its approval period |  |

|  |  |
| --- | --- |
| Describe the method that a participant would use to obtain a replacement certificate of attendance: |  |
| **ONLY** if you do ***not*** plan on maintaining your own records, you can use: “Contact the University of Cincinnati College of Nursing Continuing Education Program” | |

**J. ADVERTISING MATERIAL**

Attach a copy of **advertising material** (announcement/brochure/letter). A draft is acceptable for approval process, but **FINAL COPY MUST BE SUBMITTED** for our Approver Unit records.

|  |  |
| --- | --- |
| Type your initials to indicate that you attached a copy of the advertising tool(s). (Note: do not send or type a web link where the marketing information is located. Instead, provide a pdf or printed copy of the webpage, marketing email, flyer, etc.)  **Pending language:** “Application has been submitted for continuing education contact hours for nurses. Please contact (INSERT - organization submitting application for approval and contact information), to obtain information regarding approval status.”  **Final language -** Approved contact hours: **\_\_\_** Continuing education contact hours for nurses are approved by the Ohio Board of Nursing through the OBN Approver Unit at the University of Cincinnati College of Nursing, Continuing Education Program, (OBN-011-93). Contact hours are valid in most states. **Program #** | **Your initials:** |

**K. DOCUMENTATION OF PROGRAM ATTENDANCE**

|  |  |
| --- | --- |
| Describe how attendance will be tracked (e.g., sign-in sheet, submission of evaluation tool with name of attendee, etc.). |  |
| Describe how and who will store the attendance roster. |  |

**L. SUBMISSION OF APPLICATION FEE AND WAIVER REQUEST**

1. Indicate the method of payment for the CNE application review:

\_\_\_\_ Check

\_\_\_\_ Credit card

\_\_\_\_ Department/account transfer of funds

\_\_\_\_ Waiver request (continue to question 2)

1. Are you a faculty member, staff member, or student of the UC College of Nursing?

\_\_\_\_ Yes (continue to question 3)

\_\_\_\_ No (submit application fee)

1. Will the program be presented in space inside Procter Hall or UC East?

\_\_\_\_ Yes (a waiver of the application fee will be considered)

\_\_\_\_ No (continue to question 4)

1. Is this program being presented on behalf of a UC College of Nursing program or unit? For example, presentations to college alumni, college-sponsored conference, and Nightingale event.

\_\_\_\_ Yes (a waiver of the application fee will be considered)

\_\_\_\_ No (continue to question 5)

1. Describe the rationale for the request for waiver of the CNE application fee. Include in the description, the alignment of this program to the UC College of Nursing strategic goals.

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**M. PROGRAM DETAILS**

Complete the next page or attach your own form identifying

1. **behavioral outcomes of offering (written in full sentences using behavioral terms)**
2. **content and schedule (time frame)**
3. **faculty**
4. **faculty/participant ratio**
5. **teaching method(s)**

**M. PROGRAM DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| OUTCOMES  List outcomes in behavioral terms | CONTENT (Topics)  List each topic area to be covered and provide an outline of the content to be presented for each objective (typically 3-4 or more bullets of content is needed per 1 hour of content) | TIME FRAME  State time of day and # of minutes for each objective | FACULTY and FACULTY/ STUDENT RATIO  List faculty ***AND*** faculty/student ratio | TEACHING METHOD  Describe the teaching method(s) used for each objective |
|  |  |  |  |  |
|  |  |  |  |  |
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08/20/2021 revised lmh

05/28/2015 revised glg

01/09/2015 revised/glg

07/05/2013 revised/ek

03/02

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