**Ohio Nurses Association SAMPLE FOR REFERENCE ONLY**

**Independent Study Application Form for Individual Activity Applicants (based on 2012-2013 Criteria)**

**Demographic Data:**

OFFICE USE ONLY:

Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amt. Rec’d: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Charge to: \_\_\_\_ Credit Card \_\_\_ Send Invoice

**Yes No**

Nurse Planner – Licensed RN? \_\_\_ \_\_\_

Approval Denied by ONA (Item 8)? \_\_\_ \_\_\_

Approval Denied by Other (Item 9)? \_\_\_ \_\_\_

Invoice (check if yes): Card (check if yes):

Invoice (check if yes):

**1. Title of learning activity:**

**2. Date of form completion:**

**3. Name of organization/applicant:**

**4. Contact hours:**

**5. How long will this study be available to learners?**

**6. Contact person for this activity. Note**: If this person is also on the planning committee, be sure to include his/her name in the Planning Committee list.

Name & Credentials:

Address:

Daytime Phone including extension:

Email Address:      Organization’s website:

**7. Nurse Planner** (must have minimum of BSN) who actively planned this activity with the planning committee

1. Name & Credentials:

Address:

Daytime Phone including extension:     Email Address:

State(s) in which licensed as an RN \_\_\_\_\_\_\_\_\_\_ Nursing license number: \_\_\_\_\_\_\_\_\_\_\_\_

B. This nurse is current on CE criteria through:

     Reviewed the most current ONA Individual Activities CE Manual

     Other: Describe:

**8. My organization is a:**

     Hospital      Long term care facility

     School/college of nursing      Government agency

     Professional association      Continuing education company

     Home health agency      Health care office or practice

     Business providing services to the healthcare industry

     Other (describe)

**9.** Have you ever been denied approval by or had approval revoked for an individual activity or a provider application by ONA?

     Yes      No

If yes, please explain what happened.

**10.**  Have you ever been denied approval by or had approval revoked for an individual activity or a provider application by another approver (state or national)?     Yes     No

If yes, please explain what happened.

**11. Commercial Entities** are not eligible to submit applications for continuing education activity approval. A commercial entity is a company that produces, markets, re-sells or distributes a product that is used on or by patients or is owned or controlled by a company that produces, markets, re-sells or distributes a product that is used on or by patients. Do you meet this definition?

MCj04112440000[1]     Yes      No

If yes, Stop. Contact the Director of Continuing Education.

**12. Is this continuing education?** Does it enable the learner to acquire or improve knowledge or skills that promote professional or technical development to enhance the learner’s contribution to quality health care and pursuit of professional career goals?

     Yes      No

MCj04112440000[1]If No, Stop. An activity for nursing contact hours must be CE.

**13. Is this activity Category A** (about Ohio nursing law & rules):      Yes      No

*If yes, include the PowerPoint slides, handouts, etc. that will be given to the learner.*

**14. Assessment of Learner Needs:**

A. Identify the target audience for which this content is being designed:

     All RNs

     RNs in Specialty Areas (Identify):

     Non-certified CNS in Ohio (specialized rule requirement, see manual for details)

     Ohio APRNs with prescriptive authority (specialized rule requirement, see manual for details)

     APRNs outside of Ohio

     LPNs

     Ohio Certified dialysis techs (specialized rule requirement, see manual for details)

     Other: Describe:

1. What method was used to identify the need for this activity? (Check all that apply)

     Written Needs Assessment

     Learners/Management Requested Activity

     Quality Studies/Performance Improvement Activities

     Trends in Literature, Law & Health Care

     Other: Describe:

**Note:** Evidence of the needs assessment data must be retained in the activity file and be available to ONA upon request.

C. Describe the evidence from the needs assessment that led you to plan this activity:

D. Describe the gap that indicates where learners are now compared to where they need to/should be in relation to the knowledge or skill being addressed in this learning activity.

E. Based on the needs assessment evidence and gap analysis described above, state what outcome you wish the learner to achieve:

**15. Qualified Planners, authors, content specialists and feedback personnel:**

* For each person listed on the planning committee, please list name, educational degrees and credentials.
* Planning committees must have a minimum of one nurse planner and one other planner to plan each educational activity. The nurse planner is knowledgeable about the CE process and is responsible for adherence to ANCC criteria and OBN rules. One planner needs to have appropriate subject matter expertise for the educational activity being offered.
* According to OBN rule, if LPNs are expected in the target audience of activities based in Ohio, an LPN must be included on the planning committee.
* If this activity is specifically designed for APRNs, then an APRN must be on the planning committee.
* A content reviewer may also be included on the planning committee. The purpose of a content reviewer is to evaluate an educational activity during the planning process or after it has been planned but prior to delivery to learners, for quality of content, potential bias, and any other aspects of the activity that may require evaluation.

A. Planning Committee:

1. Nurse Planner responsible for activity *(this person was listed on p. 1, item 7 of this form)*

2. Content Expert (name, degrees, and credentials):

3. LPN (name, degrees, and credentials) if applicable:

4. APRN (name, degrees, and credentials) if applicable:

5. Other planning committee members (name, degrees, credentials):

6. Content reviewer (if applicable) (name, degrees, and credentials):

*Bio form* including conflict of interest/conflict resolution for each planning committee member is attached.

B. 1. Authors: 1) List names below and 2) attach the completed bio form for author.

a.

b.

*Bio form* with conflict of interest and conflict resolution for each author is attached.

2. Feedback personnel are those individuals who will provide feedback to the learner or assist them if having difficulties. 1) List names below and 2) attach the completed bio form for each feedback person. (OBN rule 4723-14 OAC) (Names and credentials):

a.

b.

*Bio form* with conflict of interest and conflict resolution for each feedback person is attached.

**16. Educational Design Process**

1. Explicit, measurable educational **Objectives** – document in column 1. (**Page 7** of application)

B. **Content:** List the content for each objective in column 2 (**Page 7** of application). Content must be congruent with goal/purpose and objectives. For Category A, list the ORC/OAC 4723 numeric citation with the applicable content.

C. **Teaching-Learning Strategies:** List the methods, strategies, materials and resources to be used to cover each objective in the last column of page 7 of the application. They must be congruent with objectives and content.

D. **Learner Feedback**: Check the best description or describe how you will provide feedback to the learners.

     Question and answers during learning process.

     Return results of testing.

     Return demonstration.

     Debriefing.

     Follow-up communication.

     Other: Describe:

E. **Successful Completion:** (Consistent with the outcome, objectives, and teaching and learning strategies)

1. Criteria for successful completion include: (Check all that apply)

     Completion/submission of the study and the evaluation form.

     Achieving passing score on post-test. (     %)

     Return demonstration

     Other: Describe:

1. Rationale for method selected to determine the criteria for successful completion: (Check all that apply)

Goal or purpose of event indicated what was needed to successfully complete the activity

Category of evaluation selected

Importance of content knowledge

Importance of content application

Required by employer or organization

Other: Describe:

F. **Verify Participation**

     Participation will be verified through sign in sheets/registration form/log in.

     Signed attestation statement by participant verifying completion.

     Other: Describe:

G. **Learning Activity Plan/Process** (OBN rule 4723-14 OAC)

1. Describe the entire independent study package which includes an outline of all activities of the learner:

     Article(s): Title(s):

     Audiotape: Title(s):

     Videotape/DVD: Title(s):

     On-line Program: Title(s): \_\_\_\_\_\_\_\_\_\_\_

     Registration Form

     Post-test

     Evaluation Form

List other if applicable:

2. Describe the method the learner will use to get assistance with resources or interact with the provider of the independent study:

**17. Awarding contact hours**

A. **Effectiveness of Study:** (OBN rule 4723-14, OAC)

1. Describe how the effectiveness of the independent study was assessed:
2. Describe the results of the assessment:
3. Describe the changes made based on the assessment prior to making the study available to learners**:**

B. **Contact Hour Calculation:**

1. What was the method for calculating the contact hours: (Check the best description that applies)

     Pilot Study

     Historical Data

     Complexity of content and data

     Other: Describe:

2. Show evidence of how contact hours were calculated (“show” the math).

**Note:** If this study was previously given contact hours and you wish to continue it, please include information in this section from those learners who have completed the study during the past two years rather than from the original pilot study.

Identify **Phamacotherapeutic** minutes or hours if the activity is for APRNS and the content relates to pharmacotherapeutics.

**18. Evaluation**

A. Check or describe the methods of evaluation to be used: (Check all that apply)

     Evaluation Form (Required according to OBN rule. Evaluate the achievement of each objective and how long it took the learner to complete the study). (*Attach copy)*

     Pre and/or Post-test (Optional) – (*Attach a copy if testing is to be used*)

     Return Demonstration (*Attach a copy of the tool if applicable)*

     Other: Describe:      (*Attach copy if applicable)*

1. Note: A copy of the summative evaluation must be kept in the activity file for six years. (A summative evaluation is the compilation of the results of the learners’ comments in a statistical format and a listing of all comments made by the learners. For example, if 10 participants stated they met objective 1, then you would insert the number 10 into that portion of the blank evaluation form.)

C. **Quality Improvement Process:** It is also an expectation that the nurse planner and planning committee will evaluate the activity after it is presented. In order to document this evaluation, a tool has been added to the end of this documentation form. Topics include whether the objectives were met; effectiveness of the speaker/faculty (if live presentation); presence or absence of any bias; and any changes that need to be made in the future. Please complete it and keep it in the file for six years. This is in addition to creating the summative evaluation. You may choose to add questions to the tool for your specific needs.

**19. Approved Provider Statement as noted on advertising.**

A. Include a copy of the **advertising material** including relevant pages of the web site (if applicable). Ensure that the approval statement stands alone and is worded as noted here.

**This continuing nursing education activity was approved by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.**

**Approval valid through (expiration date).**

**Note:** If marketing is being distributed prior to the receipt of approval and an application has been submitted, use the following statements:

**This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association (OBN-001-91) is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.**

**Contact (person) at (contact information) for more information.**

B. Type of advertising: *(attach copy)*

     Flyer/brochure

     Memo/Letter

     Meeting Notice

     E-mail

     Web site

     Other: Describe

**20. Documentation of completion.** Include a copy of the *completed certificate* to be awarded to learners.

Document/certificate to include:

* Name of learner
* Name and address of Provider (web address acceptable)
* Title & date of completion of educational activity
* Number of contact hours awarded
* Include pharmacotherapeutic hours if applicable
* Information about specialized OBN requirements if applicable: (See below for more detail)
* Official approval statement and length of approval statement

**This continuing nursing education activity was approved by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.**

**Approval valid through (expiration date).**

For the OBN system, include the following if applicable:

* Information about Category A (Ohio nursing law and rules): Add the words “Category A” on the certificate and indicate how many contact hours are related to Category A. For example: “5 contact hours including 1 contact hour of Category A.”
* CE specific for Ohio non-certified CNS’s, add the statement:

*This CE activity is designed for the additional hours required for non-certified CNS’s in Ohio.*

* CE specific to Ohio APRNs with prescriptive authority, add the statement:

*This CE activity is designed for the additional hours required for APRNs with prescriptive authority in Ohio.*

* CE specific to Ohio certified dialysis technicians, add the statement:

*This CE activity is designed for the hours required for Ohio certified dialysis technicians.*

* Information required by OBN for first time faculty credit. (See Chapter 1, p. 9 for statement and process)

**21. Commercial Support and Sponsorship**

* A commercial interest is defined by ANCC as any entity either producing, marketing, re-selling, or distributing healthcare goods or services consumed by, or used on, patients or an entity that is owned or controlled by an entity that produces, markets, re-sells or distributes healthcare goods or services consumed by, or used on, patients. Exceptions are made for non-profit or government organizations and non-healthcare related companies.
* Commercial Support is financial or in-kind contributions given by a commercial interest that are used to pay for all or part of the costs of a CNE activity.
* A sponsor is identified as an organization that provides financial or in-kind contributions for a CE activity and does not meet the definition of commercial interest.
* A provider of commercial support or sponsorship may **not** be on an educational planning committee, be a coprovider of the activity, or the provider of the activity.
* If commercial support is provided for a CE activity, an employee from the organization providing commercial support / sponsorship may **not** be a speaker.
* **Note:** You are not required to have a commercial support or sponsor agreement for those who are only exhibiting at the event.

If no commercial support or sponsorship received, check #A, then go to item 22.

If commercial support or sponsorship is received, complete items B, C, and D and attach the signed agreement(s).

1. This activity has no commercial support or sponsorship.
2. Commercial support/sponsorship has been provided by the following: (List name of organization(s) providing commercial support or sponsorship.)

C. Content integrity has been/will be maintained by: (Check all that apply)

     1. Our commercial support/sponsorship policy/procedure has been discussed with those providing commercial support or sponsorship.

     2. Faculty have been informed of our policy/procedure re: commercial support and sponsorship and agree to not promote the products or entity providing the financial or in-kind services. There will be no logos from the commercial entity in the CE materials.

     3. In conjunction with a-c, the session will be monitored & violators of policy will not be asked to present again.

     4. Other: Describe:

1. *Signed commercial support or sponsorship agreement attached.*

**22. Prevention of** **Bias**: Bias is defined as the process of causing partiality, favoritism or influence. (2013 Primary Accreditation Manual).The following precautions have been taken to prevent bias in the educational content:

     a. Our position on bias has been discussed with each presenter/author.

     b. Each presenter has signed a statement that says s/he will present information fairly and without bias.

\_\_\_\_ c. Each presenter has agreed to not promote his/her books, services or products.

\_\_\_\_ d. The speaker(s)’s slides and handouts have been reviewed by a content expert to ensure lack of bias.

     e. In conjunction with a-b-c, the session will be monitored & violators of policy will not be asked to present again.

     f. Other: Describe:

**23.** Written **disclosures provided to activity participants:** Learners must receive written disclosure of required items prior to beginning the learning activity. Disclosures are required to be provided for items A and B for all learning activities. Disclosures for items C and D apply only in relevant situations. Describe methods used to inform activity participants of:

A. *Outcome or objectives and criteria for successful completion (****Note:*** *Not applicable is not an acceptable response)*

     Information on advertising material. (*Attach copy)*

     Written information on handouts. (*Attach copy)*

     Other: Describe:      (*Attach copy if applicable)*

B. *Presence or absence of conflict of interest for planners, presenters, faculty, authors and content reviewers. Must disclose name of individual, name of commercial interest, and nature of the relationship the individual has with the commercial interest.*  (**Note:** Not Applicable is not an acceptable response)

     Information provided on advertising. (Should be present on advertising provided in Item 19).

     Information provided on handouts. *(Attach copy)*

     Other: Describe:      *(Attach copy)*

C. *Commercial support/sponsorship:*

     No commercial support or sponsorship received. (No statement needed)

     Information provided on advertising. *(Attach copy)*

     Information provided in handouts. *(Attach copy)*

     Other: Describe:      *(Attach copy)*

D. *Non-endorsement of products displayed in conjunction with this activity.*

     No products are being displayed. (No statement needed.)

     Information provided on advertising. (Statement to be used: “Approval status does not imply endorsement by the provider, ANCC, OBN or ONA of any products displayed in conjunction with an activity.”)

     Information provided in handouts. *(Attach copy)*

     Other: Describe:      *(Attach copy)*

E. *Expiration date for awarding contact hours for enduring materials*/*independent studies:*

     Information provided on advertising prior to the learner purchasing or starting the activity. (Required) *(attach copy)*

     Other: Describe:

**24. Recordkeeping**: 1) Check to acknowledge that you will maintain records as stated and then 2) state where records will be kept.

     All correspondence, complete copy of application, all attachments and corrections, records of attendance, summative evaluation(s) and contact hours will be maintained in a retrievable file which is accessible to only authorized personnel for six years.

     Records will be filed and stored at (**list location**)

**25: Co-providership**

If not co-providing, check #A; if yes, answer #B, C and attach signed agreement.

A.      This activity will not be coprovided.

B. Coprovidership of this activity has been arranged with: (List organization name):

C.      As the provider of this activity , we will maintain responsibility for determining of educational objectives and content, selection of planners, and presenters, faculty, authors, and content reviewer, awarding of contact hours, record keeping procedures, developing evaluation methods, and managing commercial support or sponsorship. Our name as the provider will be prominently listed in advertising.

D.      The *signed, dated, written co-provider agreement is attached.*

**Summary: *Attach the following to the documentation form*:**

* Bio forms for planning committee members and faculty
* Evaluation form and any other evaluation tools used (e.g., post-test)
* Advertising material/flyer/email announcement
* Certificate/documentation of completion
* Signed commercial support or sponsorship agreements if applicable
* Disclosures if not included on advertising; internet or intranet posting and included as bullet 4 above
* Signed coprovider agreement(s) if applicable.
* Actual slides and/or handouts if Category A

|  |  |  |
| --- | --- | --- |
| **OBJECTIVES** | **CONTENT (Topics)** | **TEACHING METHODS** |
| List learner’s objectives in behavioral terms | Provide an outline of the content for each objective. It must be more than a restatement of the objective.  If this is Ohio Category A, include numeric citation from ORC/OAC 4723. | Describe the instructional strategies & delivery methods for each objective |
|  |  |  |
|  |  |  |
|  |  |  |

**Page 7 Independent Study**

**References from speaker(s)/author(s) to show sources of best available evidence that will be discussed:**

**INDIVIDUAL ACTIVITY QUALITY IMPROVEMENT TOOL (2012-2013 Criteria)**

Please complete after each presentation of the activity done and keep in activity file with the summative evaluation for six years. If this was an independent study, complete this QI tool at the conclusion of its availability to the learner.

Activity Title:

Date(s) Given if faculty directed:

Period of time available if independent study:

Source of Information: Personal Observation      Review of Evaluations

1. Were the objectives met?      Yes      No

|  |
| --- |
| If no, please describe. |

1. For faculty directed (live) activities, was/were the faculty effective?      Yes      No

|  |
| --- |
| If no, please describe. |

1. Was there evidence of bias in the activity based on your observation or the learner evaluations?

     Yes      No

|  |
| --- |
| If yes, please describe what happened and how this will be prevented in the future. |

1. Were any changes needed?      Yes      No

|  |
| --- |
| If yes, please describe. |

1. Did this activity help fill the gap you identified in planning?      Yes      No

|  |
| --- |
| If no, please describe why not and how this will be prevented in the future. |

1. What difference did this activity make in patient outcomes or nursing professional development?

|  |
| --- |
|  |

1. Final Decision: Continue activity      End activity      Revise activity

Signature of nurse planner:

Date: