

**Ohio Department of Mental Retardation/Developmental Disabilities
CONTINUING EDUCATION (NURSING) APPLICATION
Page 1**

DIRECTIONS: PLEASE COMPLETE THESE FORMS USING THE GUIDELINES OUTLINED ON PAGE 10

Applicant Name and Address:	Telephone Number (Including Area Code)
Email	

Application Submitted for:	<input type="checkbox"/> Offering	Request for: (Check all that apply)	<input type="checkbox"/> RN
	<input type="checkbox"/> Independent Study		<input type="checkbox"/> LPN

Title should be clear and succinct and should reflect content of program.

Title of Offering/Independent Study:	
Date(s) to be held:	Advertising information: (statement which directs any party to contact the provider of approval status)

Documentation of Need should describe where the request originated (i.e., Medicaid or Licensure Deficiency, Departmental Mandate, Needs Assessment...) and what will be accomplished by this Offering or Independent Study.

Documentation of Need: (Rationale for Presentation)

Total Classroom Hours is the number of hours of offering which includes explanation/discussion of objectives, pre and/or post tests and evaluation of the offering.

The CE's for Nurses is computed based on a 60-minute hour excluding breaks and lunches. Total minutes and divide by 60.

Total Classroom Contact Hours:	CE's for Nursing:	
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You must submit a summary of the Evaluations and the Attendance Sheet(s) to the Intake Nurse within 6 weeks of the offering.

FOR CE INTAKE NURSE USE ONLY					
Date Application Received:			Approver Number:		
Approved for: (Check all that apply)	<input type="checkbox"/>	Registered Nurse	Outcome of Review:	<input type="checkbox"/>	Approved
	<input type="checkbox"/>	Licensed Practical Nurse		<input type="checkbox"/>	Denied
	<input type="checkbox"/>			<input type="checkbox"/>	Pending

If Application is denied or pending, give rationale:

<div style="text-align: right; margin-right: 100px;"> _____ Intake Nurse's Signature </div>
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Ohio Department of Mental Retardation and Developmental Disabilities
Nursing CEU Approver Unit

Instructions for Submitting Programs for Nursing Continuing Education Credit

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) is approved by the Ohio Board of Nursing (OBN) to approve Continuing Education for Nurses. To maintain this status, the ODMRDD Approver Unit must respect and adhere to established guidelines of the OBN. To obtain Continuing Education Credit for nurses from the ODMRD, one must use approved forms and follow the instructions below.

1. Complete Page 1
 - a. Complete as directed.
2. Complete Page 2
 - a. Faculty education and experience in area of content**
 - i. Add data to support that faculty is knowledgeable about content.
 - ii. List degrees earned and in which field of study.
 - b. Experience of planning committee**
 - i. List all who assisted with the planning of the offering and their discipline
 - ii. The planning committee must include 1 RN and 1 LPN if LPN's are in the target audience.
 - iii. Multi-discipline offerings should have multidiscipline planning members. Indicate areas of expertise.
 - c. Description of record keeping system**
 - i. Check the pre-printed statement, "The approved application and attendance records will be kept on file in a safe, secure location for six (6) years."
3. Complete Page 3
 - a. Behavioral objectives** must be
 - i. Stated clearly,
 - ii. Measurable,
 - iii. Attainable in the allotted time frame,
 - iv. Related to the bodies of knowledge which contribute to the appropriate discipline, and
 - v. Should describe what the participant will be able to do after participating in the offering (e.g., as a result of the course, the participant will be able to name 5 ways to....)
 - b. Content** should be
 - i. Evidence based, as well as, enhance nursing scope of practice,
 - ii. Attainable in the allotted time frame,
 - iii. Written in enough detail that the reader has a clear idea of the material, and
 - iv. Evolve from and be consistent with the objectives.
 1. The content should be delineated for each objective
 2. If presentation addresses Category A* (law/rule) it must be reflected in the objectives and content.
 - c. The Evaluation**
 - i. Evaluates the expected outcomes using the objectives as a basis. (It indicates the objectives to be attained by the participant.)
 - ii. May be immediate and/ or long term
 - iii. May be accomplished through discussion, written, or oral testing, observation, etc. (with established criteria for meeting objectives.)

Ohio Department of Mental Retardation and Developmental Disabilities
Nursing CEU Approver Unit

- iv. Includes evaluating the individual objectives and effectiveness of each faculty
 - v. Requests the participant to list any future offerings that he/she would be interested in attending
4. Complete Page 4
- a. The entire packet must be completed for an Independent Study, including page 4.
5. Complete the **Certificate**
- a. The certificate must include
 - i. Title of the presentation
 - ii. Date of the presentation
 - iii. A space for the name of the attendee
 - iv. The number of continuing education hours awarded
 - v. Any “Category A” hours as set forth in rule 4723-14-01 OAC*
 - vi. The name of the provider of the CE activity (The address is also recommended.)
 - vii. The Department Approver number as assigned by the Intake Nurse
 - viii. The objectives of the program. (Add to the front or back of the certificate.)
 - ix. The statement, “**This offering has been approved by the Ohio Board of Nursing Approver Unit of the Ohio Department of Mental Retardation and Developmental Disabilities OBN-010-93.**”
 - b. Certificates are awarded by the provider of the CE after the presentation is concluded And the attendee has participated in at least 80% of the activity.
6. Copy the final **brochure/ flyer** advertising the activity
- a. If approval is pending, advertising for continuing education activity shall include a statement which directs any interested party to contact the provider of the activity at a specified phone number to obtain information regarding the approval status.
7. **At least 6 weeks prior** to the offering, send the original collection (packet) of all the above pages plus two (2) copies [**total of three (3) packets** which include all the above material] to:

Karen Hill, RN
Portage County Board of MR/DD
Portage Industries, Inc
7008 State Route 88
Ravenna, Ohio 44266-9134

Phone 330-296-2839
Fax: 330-296-8875
Email: nursepi@portagemrdd.org

The Intake Coordinator will confirm submission of the three (3) complete packets by sending a postcard. Any missing information in the packet will also be noted on this postcard. **The application will NOT be processed until all required material is received.**

After the educational offering is provided, the CE provider must return a **copy of the sign-in sheet AND a summary of the completed evaluations** to the Intake Coordinator. Failing to complete this step will put the provider in jeopardy of not being permitted to submit future requests for approval.

Additional questions about how to complete the application for CE credit to the ODMRDD Approval Unit, may be directed to Mary Beth Hughes (see #7) , by phone (937) 910-7320 or Donna Maloney

Ohio Department of Mental Retardation and Developmental Disabilities
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RN, Nurse Consultant of the ODMRDD, by phone (614)-752-7392 or email (Donna.Malony@dmr.state.oh.us).

**Category A = the portion of Continuing Education that meets the 1-hour requirement directly related to law and rule.*

Summary of Faculty Qualifications (May Attach Vitae)

1. Name:	2. Name:
Education and Experience in Area of Content:	Education and Experience in Area of Content:
3. Name:	4. Name:
Education and Experience in Area of Content:	Education and Experience in Area of Content:
5. Name:	6. Name:
Education and Experience in Area of Content:	Education and Experience in Area of Content:

Members of Planning Committee (To Include One LPN if in the Target Audience)

1. Name:	2. Name:
Area of Expertise, Work Experience:	Area of Expertise, Work Experience:
3. Name:	4. Name:
Area of Expertise, Work Experience:	Area of Expertise, Work Experience:
5. Name:	6. Name:
Area of Expertise, Work Experience:	Area of Expertise, Work Experience:

Description of Record Keeping System: (Please mark) _____ <i>'The approved application and attendance records will be kept on file in a safe, secure location for 6 years.'</i>		
Name of Person Coordinating Offering:	Title and Profession:	Department:
Street Address:	Telephone Number (Include Area Code):	
City:	Fax Number (Include Area Code):	
State, Zip Code:	E-Mail Address:	

All Columns Must Be Completed

Page 3

Participant Centered Behavior Objectives: (Must be Measurable)	Content: (Must be Evidence Based)	Evaluation of Achievement of the Objectives:

Revise 6-07

To be submitted with Independent Study Application only

A. Faculty qualifications are included on Page #2 for the authors of the Independent Study package as well as those providing feedback and faculty in any media used.

_____ These faculty are identified as “author,” “feedback,” and/or “media” faculty on Page #2

B. _____ Page #3 identifies the behavioral objective content and evaluation feedback methods.

C. Describe how the learner will receive access feedback and from whom:

D. Describe how the number of contact hours were determined:

E. A description of the entire independent study package which outlines all activities of the learner and all materials to be used:

Page 5
Attendance Sheet

Ohio Department of Mental Retardation and Developmental Disabilities
ATTENDANCE SHEET

CE Committee Use Only
CE Application Number:

Name of Organization:	Date(s) of Offering:	Number of Contact Hours:
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Title of Offering:	Department Organizing Training
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Objectives of Offering:

- 1.
- 2.
- 3.
- 4.
- 5.

Recommendations for Future Presentations:

Summary of Evaluations:

Signature of Instructor(s):

THE FOLLOWING INFORMATION IS MANDATORY

Trainee's Name: (Print Legibly)	Nursing License Number: Or Last 4 digits of SS#:	Signature:	RN:	LPN:	OTHER:
1.					
2.					
3.					
4.					
5.					

Page 6
Attendance Sheet (Continued)

Trainee's Name: (Print Legibly)	Nursing License Number: Or Last 4 digits of SS#:	Signature:	RN:	LPN:	OTHER:
6.					
7.					
8.					
9.					
10.					
11.					
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21.					
22.					
23.					
24.					

Page 5
Attendance Sheet

Ohio Department of Mental Retardation and Developmental Disabilities
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CE Committee Use Only
CE Application Number:

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3.					
4.					
5.					

Page 6
Attendance Sheet (Continued)

Trainee's Name: (Print Legibly)	Nursing License Number: Or Last 4 digits of SS#:	Signature:	RN:	LPN:	OTHER:
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					

Category A _____ (the portion of the presentation that relates directly to law and rule)

Ohio Department of Mental Retardation And Developmental Disabilities

Nursing Certificate of Attendance

On _____ attended a training titled:

Contact Hours: _____

Approval Number: OBN-010-93-

Provided by: _____

Address: _____

This offering has been approved by the Ohio Board of Nursing Approver Unit at the Ohio Department of Mental Retardation and Developmental Disabilities (OBN-010-93). Objectives must be printed on certificate.

Page 7
EVALUATION FORM

Date: _____

Title of Presentation: _____

Please evaluate the program according to the following rating scale by circling the number that applies:

- 1. Unsatisfactory
- 2. Satisfactory
- 3. Good
- 4. Excellent

1. Were overall objectives met? Yes No

If no please explain: _____

2. To what extent did the material presented meet your expectations? 1 2 3 4

Comments _____

3. Appropriateness of presentation methods used (audiovisual, handouts, discussion sessions). 1 2 3 4

Comments _____

4. Amount of material appropriate for time allowed. 1 2 3 4

Comments _____

5. Program was well organized and logically sequenced. 1 2 3 4

Comments _____

EVALUATION OF EACH SPEAKER

Evaluate _____ in terms of the following:

(Name of Speaker)

- a) Objectives of the program met 1 2 3 4
- b) Clarity of presentation 1 2 3 4
- c) Knowledge 1 2 3 4

Evaluate _____ in terms of the following:

(Name of Speaker)

- a) Objectives of the program met 1 2 3 4
- d) Clarity of presentation 1 2 3 4
- e) Knowledge 1 2 3 4

Additional comments or suggestions for future programs:

