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| INSTRUCTIONS |  |
| This form is to be used in conjunction with Pharmacy credit Application for **Single programs only**. Please also fill out the document titled SessionInfo\_template.xls for details on each session. Separate information is needed for Technicians; this should be different than what is submitted for pharmacists. We no longer give credit for an entire day of events.  Please submit additional form along with Pharmacists application and Session Information as soon as you have a completed Agenda. Additional information can be found on the Pharmacist application form. Email this application and any supporting documents to the Continuing Pharmacy Education Administrator at [HSC-Pharmacyce@salud.unm.edu](mailto:HSC-Pharmacyce@salud.unm.edu) (505-272-3125). | |

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| PROGRAM DETAILS |  |
| **Program Title affiliated with:** Click here to enter text. | |
| **Total Number of CPE hours requested for Technicians**: Click here to enter text.  (60 minute live program is equal to 1.0 CE hour – lunch and breaks should not be included) | |
| **Topic Designator** (*only select 1*):  **01: Disease State Management/Drug** Therapy - Covers all programs that address drugs, drug therapy, and/or disease states.  **02: AIDS Therapy Related** - Covers all programs that address therapeutic, legal, social,, ethical, or psychological issues related to the understanding and treatment of patients with AIDS.  **03: Law Related to Pharmacy Practice**- Covers all programs that address federal, state, or local laws and/or regulations affecting the practice of pharmacy.  **04: General Pharmacy Topics** - Covers all programs that address topics relevant to the practice of pharmacy other than those included in the classifications of drug therapy related, AIDS therapy related, and law.  **05: Patient Safety** - The prevention of healthcare errors, and the elimination or mitigation of patient injury caused by healthcare errors (An unintended healthcare outcome caused by a defect in the delivery of care to a patient.) Healthcare errors may be errors of commission (doing the wrong thing), omission (not doing the right thing), or execution (doing the right thing incorrectly). Errors may be made by any member of the healthcare team in any healthcare setting. (definitions approved by the National Patient Safety Foundation® Board July 2003)  **06: Immunization** - activities related to the provision of immunizations, i.e., recommend immunization schedules, administration procedures, proper storage and disposal, and record keeping. This also includes review for appropriateness or contraindication and identifying and reporting adverse drug events and providing necessary first aid.  **07: Compounding** - activities related to sterile, nonsterile, and hazardous drug compounding for humans and animals. This includes best practices and USP quality assurance standards, environmental testing and control, record keeping, error detection and reporting, and continuous quality improvement processes. | |

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| PLANNING AND DEVELOPMENT | | | | |  | |
| **How were education needs(s) identified?** (*mark all that apply)* | | | | | | |
| Consensus of experts  New policy/regulation/procedure/technique  Previous evaluations [attach a copy & results]  Target audience survey [attach a copy & results] | | | | Training deficit  Needs Analysis [attach a copy & results]  Other: Click here to enter text. | | |
| **ACPE requires a written description and evidence of knowledge or skill gaps identified for pharmacists and/or pharmacy technicians.** *If any evaluations were conducted, please provide a copy of the summary and questions asked*Click here to enter text. | | | | | | |
| **ACPE requires a written a description and evidence of educational need(s) resulting from any identified knowledge or skill gap(s) for pharmacists and/or pharmacy technicians** Click here to enter text. | | | | | | |
| **How will this activity or program fulfill the identified need?** Click here to enter text. | | | | | | |
| **What is the overall program goal?** Click here to enter text. | | | | | | |
| **Learning Objectives** (*minimum of 3 per subject)*  List statements that reflect what each participant will earn from attending/participating in this program or activity. *Separate application & objectives are needed for pharmacists and technicians.* | | | | | | |
| At the conclusion of this program, the participant will be to: | | | | | | |
| Click here to enter text.  Click here to enter text.  Click here to enter text. | | | | Click here to enter text.  Click here to enter text.  Click here to enter text. | | |
| **Will off-label drug use be discussed?** No Yes  *if yes What methods of disclosure will be used?*  On printed material  Announced before program begins  Other: Click here to enter text. | | | | | | |
| **Instructional Method(s)** (*mark all that apply)* | | | | | | |
| Lecture  Monograph  Practice Session  Other: Click here to enter text. | | | | Case Study  Panel Discussion  Demonstration and practice | | |
| **How will the selected instructional method(s) contribute to the learning objectives?**  Click here to enter text. | | | | | | |
| **Delivery Method(s)** (*mark all that apply)* | | | | | | |
| Live, instructor led  Web-based instructions  Other: Click here to enter text. | | | | Self-study  Hybrid (lecture and web-based) *if yes, provide details on web-based portion (e.g., hyperlink.)*  Click here to enter text. | | |
| **Type of Activity** (*mark only ONE)* Activity will be verified upon review of content, additional information maybe be requested to validate selection made. Practice based activities will require an additional form. | | | | | | |
|  | **Activity** | | **Activity Purpose** | | | **Learning Assessment** |
|  | Knowledge (minimum 15 minutes) | | Transit Knowledge | | | Questions/Recall of Facts |
|  | Application (minimum 1 hour) | | Apply Information | | | Case studies/application of principles |
|  | Practice (minimum 15 hours) | | Instill knowledge, skills, attitudes | | | Formative and summative |
| **Speaker/Instructor and/or Coordinator and Planning Committee Information**  (list anyone directly involved with creating program content or with decision making authority about the program) – *add more rows as needed by tabbing* | | | | | | |
| **Full Name(s)** | | **Email Address** | | | | **Role** (speaker, coordinator etc.) |
| Click here to enter text. | | Click here to enter text. | | | | Click here to enter text. |

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| ACTIVE LEARNING, ASSESSMENT, EVALUATION & FEEDBACK | |  | |
| **What Active Learning strategies will be used?** (*mark all that apply)* | | | |
| Group Discussion  Case study/Scenarios  Role Playing  Lecture with Q&A  Application Exercise | | | Round Table  Problem Solving  Active Questioning  Audience response system (iClicker)  Other: Click here to enter text. |
| **Describe the active learning techniques used to foster active participation of learners along with evidence of active learning methods** Click here to enter text. | | | |
| **How will the learner assess the achievement of the desired learning objectives?** | | | |
| Pre & post-test [attach a copy of questions]  Group discussion  Other: Click here to enter text. | | | Post-test ONLY [attach a copy of questions]  Case study [attach a copy of cases]  Follow up Survey [attach a copy of questions] |
| **Please provide an explanation of how the above marked items will aid in this assessment** Click here to enter text. | | | |
| **How will the learner evaluate the quality of the program?** | | | |
| Follow up Survey  [attach a copy] | Group discussion | | Other: Click here to enter text. |
| **How will feedback from activity evaluations be used to improve the overall program** Click here to enter text. | | | |
| **Describe and show evidence of how feedback is provided to learners in an appropriate, timely, and constructive manner** *[i.e. question & answer session at the end of the presentation, feedback provided after a learning assessment etc.]* Click here to enter text. | | | |

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| ADMINISTRATORS USAGE ONLY |
| **Approved for** CEUs **contact hours of Pharmacy Continuing Education (CPE)** | |
| **Not Approved for contact hours of Pharmacy Continuing Education (CPE) for the following reasons:**  Click here to enter text. | |
| **CPE Director:** Click here to enter text. | |
| **CPE Administrator:** Click here to enter text. | |
| **Date Reviewed:** Click here to enter a date. | |
| **Notes:** | |