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| INSTRUCTIONS |  |
| This form is for **Single Pharmacists programs only** [one event held one time]. If you have more than 1 program you need CPE for, please fill out the document titled Pharmacists\_MultipleSession\_Application.doc and SessionInfo\_template.xls We no longer give credit for an entire day of events.  Please submit application as soon as you have a completed Agenda. 30 days prior to the event is the last day we will accept an application. Special circumstances will be considered with a $300 late fee applied if accepted. Supporting documentation can be submitted as they are received/created, document checklist provided. If you are not sure how to answer a question, leave it blank. The CPE Administrator will go over this with you after the form has been reviewed. 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:** Click here to enter text. | | | |
| **Program Date:** Click here to enter text.  (if more than one date or held multiple times, stop and fill out the Multiple sessions application instead) | | | |
| **Program Time** (*for live only*): Click here to enter text. | | | |
| **Program Location** (*for live only*): Click here to enter text. | | | |
| **Total Number of CPE hours requested**: 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** - activities that address drugs, drug therapy, and/or disease states.  **02: AIDS Therapy Related** - activities that address therapeutic, legal, social, ethical, or psychological issues related to the understanding and treatment of patients with HIV/AIDS.  **03: Law Related to Pharmacy Practice** - activities that address federal, state, or local laws and/or regulations affecting the practice of pharmacy.  **04: General Pharmacy Topics** - activities that address topics relevant to the practice of pharmacy other than those included in the classifications of drug/disease therapy related, HIV/AIDS therapy related, and law.  **05: Patient Safety** - activities that address topics relevant to the prevention of healthcare errors and the elimination or mitigation of patient injury caused by healthcare errors.  **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.  **08: Pain Management** - activities that address any component regarding the treatment and management of pain, including the prescribing, distribution and use of opioid medications, and/or the risks, symptoms, and treatment of opioid misuse/addiction | | | |
| **Will this be a recurring program?** (*more than 1x per year OR annually*)  No  Yes  If, **yes** please STOP & fill out the Multiple session application and not this single event app. | | | |
| **Program Organizer(s) Information:** Click here to enter text.  (Name, org., phone#, email. This person is responsible for all communication, paperwork & fee’s) | | | |
| **Contact information** (*name, phone# & email etc. if diff. than organizer*): Click here to enter text.  (to be displayed in LMS system for participants to contact for additional program information) | | | |
| **Program Website URL:** Click here to enter text. | | | |
| **What costs/fee are associated with Program?**  (attached in separate document if needed) | **Registration Fees?** | | $ enter text. |
| **Instructor Fee (honorarium etc.)?** | | $ enter text. |
| **Will there be Financial support for CPE activity?** Yes  *if yes provide details below* No  Pending | | | |
| If you answered “**yes**” to above, please check all that apply regarding this CPE activity  financial support was provided by a commercial interest (e.g. pharmaceutical and/or device manufacturer)  financial support was provided by a non-commercial interest (i.e. foundation, government, etc.)  financial support was provided by only 1 grant supporter  fully supported (100%) by grant(s)  partially supported (<99.9%) by gran(s)  activity would be conducted despite receipt of grant support  activity would not be conducted if grant support was not received  If any of these above items have been checked off, please explain the details specific to the funding. **Who, What, How, When**. Be as detailed as possible when describing the specifics of financial support. Attach additional file if needed. If pending send details as soon as possible. Click here to enter text. | | | |
| **Competencies** [mark all that apply – must be able to provide proof for each choice as needed] | | | |
| **Knowledge**  **Foundational Knowledge** [(Learner) - Develop, integrate, and apply knowledge from the foundational sciences (i.e., pharmaceutical, social/behavioral/administrative, and clinical sciences) to evaluate the scientific literature, explain drug action, solve therapeutic problems, and advance population health and patient-centered care.]  **Practice and Care Approaches**  **Problem-solving** [Identify problems; explore and prioritize potential strategies; and design, implement, and evaluate a viable solution.]  **Educator** [Educate all audiences by determining the most effective and enduring ways to impart information and assess understanding.]  **Patient** **Advocacy** [Assure that patients’ best interests are represented.]  **Interprofessional collaboration** [Actively participate and engage as a healthcare team member by demonstrating mutual respect, understanding, and values to meet patient care needs.]  **Cultural Sensitivity** [Recognize social determinants of health to diminish disparities and inequities in access to quality care.]  **Communication** [Effectively communicate verbally and nonverbally when interacting with an individual, group, or organization.] | | **Practice and Care Essentials**  **Patient-centered care** [(Caregiver) - Provide patient-centered care as the medication expert (collect and interpret evidence, prioritize, formulate assessments and recommendations, implement, monitor and adjust plans, and document activities).]  **Medication use systems management** [(Manager) - Manage patient healthcare needs using human, financial, technological, and physical resources to optimize the safety and efficacy of medication use systems.]  **Health and wellness** [(Promoter) - Design prevention, intervention, and educational strategies for individuals and communities to manage chronic disease and improve health and wellness.]  **Population-based care** [Describe how population-based care influences patient centered care and influences the development of practice guidelines and evidence-based best practices.]  **Personal and Professional Development**  **Self-awareness** [Examine and reflect on personal knowledge, skills, abilities, beliefs, biases, motivation, and emotions that could enhance or limit personal and professional growth.]  **Leadership** [Demonstrate responsibility for creating and achieving shared goals, regardless of position.]  **Innovation and Entrepreneurship** [Demonstrate responsibility for creating and achieving shared goals, regardless of position.]  **Professionalism** [Exhibit behaviors and values that are consistent with the trust given to the profession by patients, other healthcare providers, and society] | |

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| JOINTLY PROVIDED PROGAMS ONLY |  |
| **Is this a jointly provided activity?** Yes  No  *If no, proceed to the next Section* | |
| **Is the providing organization an ACPE accredited CE provider?**  Yes  No | |
| For each providing organization, provide a Letter of Agreement outlining responsibilities and conditions of joint Providership.  *attached* | |
| **Organization Information:** Click here to enter text.  (organization name, address, contact person, phone and email address) | |

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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 [provide references]  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. | | |
| **Planning Process** How did your planning committee determine the topics and speakers for this activity? If there are minutes or notes from a scheduled meeting, please attach: Click here to enter text. | | | | | | |
| **What evidence of knowledge or skill gaps were identified for pharmacists and/or pharmacy technicians***. What data or information did you use to help identify the gap? What is the source of your data or information? If any evaluations were conducted, please provide a copy of the summary and questions asked*Click here to enter text. | | | | | | |
| **Provide 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 [presented live]  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 in person  Web-based  Online [Zoom, Microsoft teams etc.]  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. | | |
| **Are you currently using non-educational strategies to address this issue?** *Examples: sending reminders about techniques or information discussed at a CE activity; patient surveys; peer feedback; on-demand Web resources.*  Yes  No If yes, please explain: 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:** | |

Document Checklist

The following documents are required for Continuing Education accreditation. Electronic files preferred, scanned copy accepted.

**Before event:**

Completed Accreditation Application with approval

Signed Contract of Duties (if needed)

Completed Disclosure Statements from all presenters, coordinator’s & anyone directly contributing to content presented or with decision –making authority about the content.

Current CV for all presenters [no older than 3 years]

Draft of program syllabus/brochure/schedule of events/agenda

Draft of program advertisement (specific wording will be provided to you to be included)

Copy of all materials presented (no later than one week before event date)

**After event:**

Copy of all materials presented if changes were made or not previously sent

Final program syllabus/brochure/schedule of events/agenda

Final program advertisement with ACPE Continuing Pharmacy Credit required text

Summary of Evaluation results

**Conclusion of Program:** Invoice will be issued for fees accrued 1 month after the event. Reporting hours and evaluation summaries will also be provided at this time.