

Pharmacy Continuing Education

Accreditation Request Form

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| **I. Program Details** | | | |
| A. Program Title: | | | |
| B. Program Date(s):      (beginning and ending dates) **MUST BE NO SOONER THAN 1 MONTH AWAY** | | | |
| C. Program Time(s):       (for live only, this will apply when using multiple UPN’s) | | | |
| D. Program Location(s):       (for live only) | | | |
| E. Number of continuing education hours requested:  (60 minute live program is equal to 1.0 CE hour – lunch and breaks should not be included) | | | |
| F. Breakdown of each session for multiple UPN’s  Name of session | Requested Hours for corresponding session | | |
| G. Target Audience:  Pharmacists  Technicians | | | |
| H. Topic Designator (only select 1):  01: Drug Therapy Related - 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 - 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) | | | |
| I. Will this be a recurring program? (more than 1x per year OR annually)  No  Yes If, **yes** please specify details of how often [annually, monthly etc.]: | | | |
| J. Program Organizer(s):  (Name, organization, phone, email. This person is responsible for all, communication, paperwork and fee’s) | | | |
| K: What costs/fee are associated with Program? | Registration fee: $  Instructor fee (honorarium etc.): $ | | |
| L. Financial support for CPE activity. yes 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 | | | |
| **II. Jointly Sponsored Programs Only** | | | |
| A. Is this a jointly sponsored activity? Yes  No  If no, proceed to Section III | | | |
| B. Is the sponsoring organization an ACPE accredited CE provider? Yes  No | | | |
| C. For each sponsoring organization, provide a Letter of Agreement outlining responsibilities and conditions of joint sponsorship. | | | |
| D. List below organization name, address, contact person, phone and email address | | | |
| **III. Planning and Development** | | | |
| A. How were educational need(s) identified?  Target audience survey  Training deficit  Other: | Consensus of experts  New policy/regulation/procedure/technique  Previous evaluations | | |
| B. How will this activity or program fulfill the identified need? | | | |
| C. Goal(s):What is the overall program goal? | | | |
| D. Learning Objectives: List statements that reflect what each participant will earn from attending/participating in this program or activity. At the conclusion of this program, the participant will be to: | | | |
| E. Instructional Method: Mark all that apply. | | | |
| Lecture  Monograph  Practice Session  Other: | Case Study  Panel discussion  Demonstration and practice | | |
| F. How will the selected instructional method(s) contribute to the learning objectives? | | | |
| G. Attach a copy of the program outline/abstract or handouts of the content to be presented. | | | |
| H. Delivery Method: | | | |
| Computer based instruction (CD based)  Live, instructor led  Other | Web-based instruction  Self-study  Hybrid (lecture and web-based) | | |
| I. Type of Activity (check only one): | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  | **Activity** | **Activity Purpose** | **LearningAssessment** | |  | Knowledge (minimum 15 minutes) | Transit Knowledge | Questions/Recall of Facts | |  | Application (minimum 60 minutes) | Apply Information | Case studies/application of principles | |  | Practice (minimum 15 hours) | Instill knowledge, skills, attitudes | Formative and summative | |  |  |  |  | | | | |
| J. List of Speakers/Instructors | | | |
| **Full Name(s)** | | **Email address’** | |
|  | |  | |
| **IV. Assessment and Evaluation** | | | |
| A**.** How will the learners assess their achievement of the desired learning objectives? | | | |
| Pre & post test  Group discussion  Other: | Post test only  Case study  Follow up survey | | |
| B. How will the learner evaluate the quality of the program? | | | |
| Follow up survey  Group discussion | Other: | | |
| **V. Advertisement** | | | |
| What sort of advertisement will be issued?       (Brochure, Flier, Internet etc.) Attach if already created. Specific wording is required and will be sent to you upon approval of CE program. | | | |
| **VI. Statement of Credit** | | | |
| Documentation that participants have/have not met requirement for receiving credit:      (sign in sheet, etc.) | | | |
| Certificates will no longer be issued, all CPE will be submitted through CPE Monitor with-in 1 month. NABP ePID and MM/DD is required, no exceptions. A Request for credit will be provided to request CPE for event. A typed list of all participants is required from the Organizer. | | | |
| **VII. Faculty** | | | |
| A. Attach the following information for each participating member.  Name, affiliation, address, phone and email  Current CV  Faculty disclosure statement | | | |
| B. Will off-label use be discussed? Yes  No | | | |
| C. What methods of off-label disclosure will be used?  On printed material  Announced at program beginning  Other: | | | |
| **VIII. Accreditation Action** | | | |
| A. Date submitted for review: | | |  |
| B. Recommended for       contact hours of continuing pharmacy education (CPE) | | | |
| By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (electronic confirmation is accepted)  Program Organizer Signature | | | |
| **IX. Accreditation Approval** | | | |
| Approved for       contact hours of pharmacy continuing education (CPE)  Not approved for pharmacy continuing education credits for the following reasons | | | |
| By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CPE Director Date | | | |
|  | | | |
| Universal Program Number assigned:       Expiration Date: | | | |
| By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CPE Administrator Date: | | | |