

# UMDNJ-Center for Continuing and Outreach Education

## Continuing Nursing Education

### Activity Information and Checklist

1. Title Date(s) of Presentation

2. Address of Presentation Time to be held

3. Name of Sponsor Organization and/or Agency (May be more than one)

4. Name and Title of Individual Submitting Application

5. Address for Correspondence

Telephone:  
Fax:  
E-Mail:

Activity Code #
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#### OFFICIAL USE ONLY

#### CHECK-OFF LIST

**Forms Completed:**

- Educational Activity Information and Checklist Form
- Biographical Data Formats for Content Specialists/Lectures (Form A)
- Objectives, Content, etc. (Form B)
- Contact Hours Certificate (Form C)
- Evaluation Form (Form D)
- Sign-In Sheet (Form E)
- Co-Provider Agreement (Form F)
- Vested Interest Form (Form G)
- Summary of Evaluations
- Marketing Items

**Information Needed: (check when received)**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

RESPOND TO ALL AREAS

6. Planning Committee consists of a minimum of one RN with a BSN (List all members)

7 (a). Biographical Data Forms or CV's are included for all members of the planning committee. (Each planning committee members must submit a form) Yes No

(b). Biographical Data Forms of presenters prove expertise in the content to be presented. (Each presenter must submit a form) Yes No

8. Explain how presenters were involved in planning (Check all that apply)

Member(s) of planning committee

Involved in development of objectives/content/teaching strategies

Other (Describe)

9. Target Audience (Check all that apply)

LEVEL OF EDUCATION: Diploma  Associate  Baccalaureate  Master  Doctorate

PRACTICE AREA: Acute Care  Critical Care  Peri-Op  Medical/Surgical   
Pediatrics  Psych  OB/GYN  Community Health   
Education  Administration  Advanced Practice  Other

10. Assessment for activity was determined by (Check all that apply)

- a. Learner population
- b. Planning Committee
- c. Community Need
- d. Consumer Interest
- e. New Concepts/Technology
- f. Committee Minutes
- g. Other (Describe):

Describe in paragraph format the process used in planning your activity (objectives, content, teaching-learning strategies). Attach additional sheets if more room is required.

11. Purpose of Activity:

12. Document the objectives, content, teaching-learning strategies and time frame.  
**(Complete Form B)**

13. Number of Contact Hours in proposed activity:

(50 minutes of learning activity equals one contact hour)

14. Explain methods to be used for evaluation (Attach Evaluation Sample)

- a. Completed evaluation
- b. Post test
- c. Return Demonstration
- d. Case Study
- e. Q&A Session/Discussion
- f. Other (Describe)

15. Provide a copy of the evaluation data form used.

16 (a). Describe how the evaluation data will be used.

(b). What will be your basis in revising ongoing activities?

17 (a). Process to be used to verify completion of activity

- a. Attendance/Sign-In Sheet
- b. Completion of Evaluation
- c. Written Post-Test
- d. Verbal Discussion
- e. Return Demonstration
- f. Certificate
- g. Explanation of Other Method used for Verifying Attendance

(b). Process that will be used to inform the learners of the requirements for completion of:  
(Check all that apply):

- a. Promotional materials
- b. Written instructions
- c. Announcements
- d. Other (Describe)

18. Is this activity co-provided? If it is co-provided, describe the responsibilities of each party.

NO  YES  (Attach copy of agreement)

19 (a). Include Educational Activity Brochure/Marketing/Promotional Material attached.

(b) Does your promotional material reflect appropriate language? i.e., UMDNJ-Center for Continuing and Outreach Education is an approved provider of continuing education by the New Jersey State Nurses Association.....

Commercial Support:

20 (a). Is this activity receiving commercial support? YES  NO

(b). If yes, describe how you will maintain control of the educational content, disclosure financial relationships, and inform learners of commercial products used during activity.

(c).How will the learners be informed of any off-label use of a commercial product if used in the presentation?

21. Presenters have vested Interest/Speaker Agreement Form attached: YES  NO

# FORM A

## AMERICAN NURSES CREDENTIALING CENTER COMMISSION ON ACCREDITATION BIOGRAPHICAL DATA FORMAT\*

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**Instructions:** This format may be used to provide documentation of an individual's expertise when required by an evidence statement.

Name:

Preferred Address

(Number and Street)

(City, State, Zip Code)

Preferred Telephone:

Present Position (Employer, title and description)  
(Write in paragraph format position description)

Education (Include basic preparation through highest degree held)

Degree	Institute (Name, City, State)	Major Area of Study	Year Degree Awarded

Use the space below to briefly describe your professional experience or areas of expertise (including publications) related to your involvement in continuing nursing education and your particular role, e.g., planner, presenter, peer reviewer, administrator, etc.

# FORM B

## EDUCATIONAL ACTIVITY SAMPLE FORM

Title of Activity:  
Total # of Contact Hours

Date of Activity:

<b>Objectives</b> Upon completion of this activity, the learner will be able to:	<b>Content (Topics)</b> (Align with each objective)	<b>Time Frame</b> (In minutes)	<b>Presenter</b>	<b>Teaching Strategies</b>
1.				
2.				
3.				
4.				
5.				
		Total Minutes = / 60 = CH		

**NOTE:** Evaluation time is counted when calculating contact hours. Include time scheduled for evaluation and question & answer session on this form.

SAMPLE  
EVALUATION FORM FOR EDUCATIONAL ACTIVITY

CODE  
A=Excellent  
B=Good  
C=Fair  
D=Poor  
E=N/A

1. How well were the following objectives met?  
(These objectives MUST BE taken from the Offering Documentation Form)

Objective #

Objective #

Objective#

Objective #

Objective #

2. Relationship of objectives to overall purpose/goals of activity?

3. How well did this offering meet your expectations?

4. Please evaluate **PHYSICAL FACILITES:**

- A. Accommodation of Teaching Strategy
- B. Environmental Comfort
- C. Target Audience Accessibility

5. Please evaluate **EACH** speaker:

**SPEAKER** (Name)

- A. Knowledge of subject
- B. Presentation orderly and understandable
- C. Effective use of teaching tools (small groups, role-playing, assignments)

**SPEAKER:** (Name)

- A. Knowledge of subject
- B. Presentation orderly and understandable
- C. Effective use of teaching tools (small groups, role playing, assignments)

**SPEAKER :** (Name)

- A. Knowledge of subject
- B. Presentation orderly and understandable
- C. Effective use of teaching tools (small groups, role playing, assignments)

6. Overall, I found the learning experience

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Comments:

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FORM C

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY  
CENTER FOR CONTINUING AND OUTREACH EDUCATION  
CONTACT HOUR CERTIFICATE

THIS IS TO CERTIFY

\_\_\_\_\_

HAS SUCCESSFULLY COMPLETED

TITLE: \_\_\_\_\_

CONDUCTED BY:

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Activity Number: \_\_\_\_\_

Location of Educational  
Activity: \_\_\_\_\_

(City and State)

Contact Hours: \_\_\_\_\_

\_\_\_\_\_

PROGRAM COORDINATOR

The University of Medicine and Dentistry of New Jersey- Center for Continuing and Outreach Education is an approved provider of continuing nursing education by NJSNA, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Provider Number P173-10/06-09.

This activity is awarded \_\_\_\_\_ contact hours. (60 minute CH)

Provider approved by the California Board of Registered Nursing, Provider Number CEP 13780. This document needs to be retained by the licensee for a period of four years after the course concludes.

FORM F

**CO-PROVIDER AGREEMENT**

(If this does not apply, state "Not Applicable")

AGREEMENT made as of the \_\_\_\_\_ day of \_\_\_\_\_ between \_\_\_\_\_ and  
(Approved Provider)

\_\_\_\_\_  
(Co-Provider's Name)

WHEREIN, IT IS MUTUALLY AGREED AS FOLLOWS:

1. \_\_\_\_\_ and the Co-Provider shall provide an educational offering entitled,  
(Approved Provider Organization)  
"\_\_\_\_\_."

2. \_\_\_\_\_ shall provide:  
(Approved Provider Organization)

- 1. Determination of objectives and content.
- 2. Selection of presenters.
- 3. Awarding of contact hours.
- 4. Record Keeping.
- 5. Evaluation.

3) \_\_\_\_\_ and the Co-Provider shall jointly share the responsibilities  
(Approved Provider Organization)  
for the program as follows:

<u>ITEM</u>	<u>BY APPROVED PROVIDER</u>	<u>BY CO-PROVIDER</u>
Printing of	_____	_____
Announcement	_____	_____
Publicity	_____	_____
- Direct Mail	_____	_____
- Journals	_____	_____
- Posting in Agency	_____	_____
- Newspaper	_____	_____
Postage	_____	_____
Program Packet	_____	_____
- Name Tags	_____	_____
- Folder Materials	_____	_____
Instructor's Honorarium	_____	_____
Space	_____	_____
Audio/Visual	_____	_____
Equipment	(will order)	_____
Lunch & Coffee Break/Refresh.	_____	_____

\_\_\_\_\_ may at its sole option, cancel the program if there are less than \_\_\_\_\_ paid registrants.  
(Approved Provider Organization)

IN WITNESS WHEREOF, the parties hereto have set their hand and seal as of the day and year first above written.

FORM G

SPEAKER AGREEMENT AND VESTED INTEREST FORM

Name of Presenter

Date of Activity

Title of Activity

TERMS AND CONDITIONS

The undersigned presenter understands and accepts the following rules as required by the American Nurses Credentialing Center:

1. **DISCLOSURE** – All presenters must complete and submit a Disclosure Statement to the Provider Unit. The Disclosure Statement shall be complete and truthful to the best of the speaker’s knowledge. As faculty, you are required to disclose any financial relationship you have with any product or class of products you plan to discuss in this educational activity.
2. All presenters are required to prepare **fair and balanced presentations**, which are objective and scientifically rigorous.
3. Presentations, which provide information in whole or in part related to non-FDA approved uses for drug products and/or devices, must clearly acknowledge the unlabeled indications or the investigational nature of their proposed uses to the audience. If you plan to discuss non-FDA approved uses for commercial products and/or devices you must advise the Provider Unit of your intent.
4. This activity may be supported through an unrestricted educational grant from a commercial organization. Faculty is **not permitted to receive any direct remuneration or gifts** from any company nor should you be subject to direct input from any company regarding the content of your presentation.

**VESTED INTEREST DISCLAIMER**

1. Describe any financial interest(s) with the commercial supporter of this activity and any product or device related to your presentation.  
 Research Support  
 Consultant  
 Shareholder  
 Speaker/Speakers Bureau  
 Other Financial Support

2. Unlabeled and Unapproved uses of Products  
 \_\_\_\_\_ I intend to discuss either non-FDA—approved or investigational use of the following products or devices:

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\_\_\_\_\_ I do not intend to discuss a non-FDA approved or investigational use of any product/device

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Signature

Date

**FORM E**

**EDUCATIONAL ACTIVITY SIGN-IN SHEET**

60

**TITLE:**

**ACTIVITY NUMBER:**

**SPONSORING AGENCY:**

**DATE:**

**R.N. PARTICIPANT (Please Print)**

**ADDRESS**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.
- 18.
- 19.
- 20.

## **Continuing Nursing Education (CNE) - Activity Checklist**

Types of educational activities for Nursing:

- Live activity - participant attendance
- Enduring Material/Self-Learner - independent learning experience

To be provided credit, activities need to have the following completed for review. Allow for up to 2 weeks for the review from date of receipt. Please submit to:

Barbara Nadir, Accreditation & Standards Coordinator  
UMDNJ-Center for Continuing and Outreach Education  
30 Bergen St., ADMC 7-710  
P.O. Box 1709  
Newark, NJ 07101-1709

**Remember:** a nurse must be involved in the planning process of the activity at its earliest stages. If you need assistance selecting a nurse planner/content specialist or if you have any questions, contact Patricia Wrobbel at Phone: 973-972-8978 or E-mail: wrobbepa@umdnj.edu

### **Needed for both Live and Independent Self-Learning activities:**

- Nursing Credit Review Fee:  
To be invoiced accordingly
- Complete 5-Column Educational Design Activity Information Form. Activity Content, Time Frame, Presenters, and Teaching Strategies must be listed on this form
- Prepare a Biographical Data Format **OR** a current CV for all planners, content specialists, coordinators, reviewers and presenters associated with this activity
- Draft Activity Evaluation Instrument
- Estimated Budget for Activity
- Draft of Promotional Materials
- If Co-Provided, a signed Co-Providership Agreement (This pertains **only** to Nursing Co-Providership)
- Speaker Agreement /Vested Interest forms

### **Additionally for Enduring Activities:**

- Description of content experts (these can be the speakers/presenters) and how they participated
- Learner Evaluation Instrument (e.g. Post Test with approximately 10 multiple choice questions for each contact hour evenly distributed for the Objectives of the Activity)

Note: We will be field-testing the activity. Please allow an additional 10 to 14 days for review.

### **Upon Completion of Activities:**

- Copy of the Sign-in Sheets or Participant Roster
- Summary of Activity Evaluations
- 3 copies of actual Promotional Materials (i.e. brochure, CD-ROM, video, etc.)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

PROVIDER STATEMENT FOR UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

Remember to include the following statement on all marketing materials and communications to describe the current approved status:

The University of Medicine and Dentistry of New Jersey- Center for Continuing and Outreach Education is an approved provider of continuing nursing education by NJSNA, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is awarded \_\_\_\_\_ contact hours. (60 minute CH)

Provider approved by the California Board of Registered Nursing, Provider Number CEP 13780.

ENDORSEMENT OF COMMERCIAL PRODUCTS

Displays of commercial products may occur in conjunction with educational activities for nursing. Marketing materials for approved activities must state that approval of the activity does not imply the University of Medicine and Dentistry of New Jersey – Center for Continuing and Outreach, ANCC COA, NJSNA or California Board of Registered Nursing approval or endorsement of any commercial products. Whenever commercial products are displayed, a statement reflecting this must be in written materials, as follows:

“Accreditation refers to recognition of continuing nursing education activities only and does not imply the University of Medicine and Dentistry of New Jersey – Center for Continuing and Outreach Education, NJSNA, California Board of Registered Nursing or ANCC Commission on Accreditation approval or endorsement of any commercial product.”

**FOR INDEPENDENT STUDY ACTIVITIES**

Remember to include the following statement on independent study activities:

" Nursing credit for this activity will be provided through <ENTER DATE>."