Allen College
UnityPoint Health

Continuing Education Application

INSTRUCTIONS: Complete the application and forward to the Allen College Continuing Education Department **4 weeks prior to program advertising**. The department will communicate denial or send to the program developer, the necessary forms.

This document has been revised in accordance to revisions to 655 IAC Chapter 5 Rules and is effective as of June 1, 2022.

PLANNING PROCESS **(Type or print legibly)** Today's Date: _____

Coordinator/Contact Name: _____

Address: _____

Phone Number: _____ E-mail: _____

Professional (RN) involved in program planning: _____

All of the following must be completed for approval.

TITLE: _____

DATE: _____ **TIME:** _____

LOCATION: _____

INTENDED AUDIENCE (include specialty areas, if any)**:** _____

FACULTY/SPEAKER: (must attach vitae and if there is a sponsor have faculty disclosure statements signed)

PURPOSE: Identify gaps in knowledge, skill or practice. For example: has there been a change in standards of care, is there a problem in practice and is there an opportunity for improvement?

OBJECTIVES: Objectives should be developed in consideration of the desired state of knowledge, skill and/or practice that is desired upon completion of this program. Objectives should be measurable and must speak to the behavior or performance expected by the participant at the completion of this program.
At the completion of the program the participant should be able to:

TEACHING/LEARNING STRATEGIES:

AGENDA: If the program is more than one hour long, attach an agenda.

NARRATIVE OF THE PLANNING: What has been done to analyze the need for this program? How were knowledge, skill or practice gaps identified? Has this been supported by evidence based practice literature or research? Provide data and information to validate the need to plan the educational activity. This may be provided as a separate attached document as desired.

BUDGET: A preliminary budget **must** be included with all program requests having a registration fee greater than $10.

SPONSOR: ☐ Yes, this program will be supported by an educational grant from a commercial institution(s). Attach list, contact info, and amount of support. The speaker will have to complete a faculty disclosure form. (Attach a list of who is providing an educational grant and how much)
☐ No commercial support will be received.

PREREGISTRATION: ☐ Yes by mail or calling (who) _____ at # _____

REGISTRATION FEE: $_____ (Please add additional $10 for Allen College recording fee per participant)

CE CREDIT: Credit applying for: ☐ Contact Hours for nurses only ☐ Contact Hours for nurses and non-nursing participants

Nursing Certificate of Completion: "This program has been approved for_____Contact Hours through Allen College, Iowa Board of Nursing provider #127. Participants must attend the entire session to receive credit."

REGISTRATION PROCESS

Anticipated number of certificates and evaluations requested (estimated attendance) _____

Maximum enrollment capacity of your program _____

Open to non-Allen Health Systems employees ☐ Yes ☐ No

The program event planner will be responsible for returning all necessary documents (completed sign-in sheets showing signature and RN license #, completed evaluation forms, faculty vitae, coordinator summary, etc.) to Allen College Continuing Education department within 5 working days after the program.

The program coordinator may be responsible for collecting money and remitting to Allen College Continuing Education department within 5 working days after the program. If money is to be collected, please discuss options with the Continuing Education Coordinator.

A $10 charge per certificate will be applied to every Continuing Education event.

Program cancellation: If the program is cancelled for any reason, the program coordinator must notify Allen College Continuing Education within 24 hours of cancellation.

If you have any questions, please contact Continuing Education at (319) 226-2011.

Who will be responsible for registering participants? ☐ Program Coordinator from top of 1st page or ☐ other as listed below:

Name _____

Address _____

Phone Number _____

For Continuing Education Office Use Only

☐ Program approved for_____Nursing Contact Hours

☐ Program not approved for Contact Hours credit because:

CE Coordinator Signature _____ Date _____

Dean of Nursing Signature Date _____

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