**APPROVER UNIT APPLICATION**

**American Public Health Association**

**Individual Educational Activity**

**Applicant Eligibility Verification**

**Section 1: Type of Continuing Education Credit Requested (check all that apply)**

[ ]  **CME-continuing medical education (joint sponsorship)**

[ ]  **CNE – continuing nursing education**

[ ]  **CHES – certified health education specialist (CHEC)**

**Section 2: Type of Activity for CE credit (check all that apply)**

 [ ] Provider-directed, provider-paced: **Live** **Course** (in person or webinar)

* Date of live activity: Click here to enter a date.
* Location of the activity
* Number of contact hours to be awarded and method of calculation

 [ ] Provider-directed, learner-paced: **Internet Non-Live Course (**Enduring material)

* Start date of enduring material: Click here to enter a date.
* Expiration/end date of enduring material: Click here to enter a date.
* Number of contact hours to be awarded and method of calculation

 [ ] Learner-directed, learner-paced: **Internet Non-Live Course (**Enduring material)

* Start date of enduring material: Click here to enter a date.
* Expiration/end date of enduring material: Click here to enter a date.
* Number of contact hours to be awarded and method of calculation

[ ] Blended activity **Regularly Scheduled Series**

* Date(s) of enduring materials (e.g. prework): Click here to enter a date.
* Date of live portion of activity: Click here to enter a date.
	+ Number of contact hours to be awarded and method of calculation

**Section 3: Eligibility**

Applicants interested in submitting an individual educational activity for approval or joint sponsorship must complete the Eligibility Verification and meet all Eligibility Requirements. Verification forms received from applicants that do not meet Eligibility Requirements will be rejected without substantive review.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Organization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip/Postal Country

**Identify Organizational Types** (*check all that apply*):

[ ]  Constituent Member Associations of ANA

[ ]  College or University

[ ]  Healthcare Facility

[ ]  Health - Related Organization

[ ]  Multidisciplinary Educational Group

[ ]  Professional Education Group

[ ]  Specialty Organization (nursing, medical, public health, health education)

[ ]  Non-Profit Organization

[ ]  Government

[ ]  Other: Describe -

|  |
| --- |
| Primary Point of Contact: Name and CredentialsTitle/Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number E-mail Address  |

* Has the applicant ever been denied **accreditation by ANCC, ACCME or NCHEC** or had its accreditation status suspended or revoked? [ ]  Yes [ ]  No

If yes, please provide the following information:

Date:       Action:       Denial       Suspension       Revocation

Brief description:

* Has the applicant ever been denied **approval/joint sponsorship/co-providing**  or had approval/joint/co-providing suspended or revoked for an individual activity that was to have CE credit for nursing, health educators, physicians or non-physicians seeking Category I CME? [ ]  Yes [ ]  No

If yes, please provide the following information:

Date:       Action:       Denial       Suspension       Revocation

Brief description:

* A currently licensed registered nurse with baccalaureate degree or higher in nursing is actively involved, as the nurse planner, in the planning, implementing and evaluation process of this continuing education activity.

[ ]  Yes [ ]  No [ ]  Not Applicable – not seeking CNE credit

Please list the name and credentials of the nurse involved/responsible for this educational activity:

|  |  |
| --- | --- |
| **Nurse Planner's Name** | **Credentials & Identify Nsg Degree(s)**  |
|  |  |
| **(Required) Nurse Planner License:** | **(Required) State**  | **(Required) Expiration date:** |

* A currently licensed physician is actively involved, as the physician planner, in the planning, implementing and evaluation process of this continuing education activity.

[ ]  Yes [ ]  No [ ]  Not Applicable – not seeking CME credit

Please list the name and credentials of the physician involved/responsible for this educational activity:

|  |  |
| --- | --- |
| **Physician Planner's Name** | **Credentials & Identify Nsg Degree(s)** |
|  |  |

* A currently certified health education specialist is actively involved, as the health education planner, in the planning, implementing and evaluation process of this continuing education activity.

[ ]  Yes [ ]  No [ ]  Not Applicable – not seeking CHES credit

Please list the name and credentials of the health educator involved/responsible for this educational activity:

|  |  |
| --- | --- |
| **Health Education Planner's Name** | **Credentials** |
|  |  |
| **CHES Planner License #:** |  |

**Do you have or plan to have commercial and or sponsorship report for this activity?**[ ]  Yes [ ]  No

If yes, please name commercial or sponsorship entities and the amount you expect.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Title of Activity** |  |
| **Date(s) of Activity** |  |
| **Time of Meeting** |  |
| **Location and Address of Activity** |  |
| **Registration Fee(s):** |  |
| **CE Fee (if applicable)** |  |
| **Expected Attendance** |  |
| **Anticipated # of Credits** |  |
|  |  |
| **Length of the program/activity**  | \_\_\_\_\_\_a multi-day program/activity, specify No. of days - \_\_\_\_\_\_\_\_\_\_\_on-going online, web-based material\_\_\_\_\_\_Less than an 8-hour day, but at least a 1-hour program (a minimum time) \_\_\_\_\_\_an 8-hour day program/activity |

**Section 4: Commercial Interest**

**The following section is intended to collect information about the applicant's organizational structure. Some applicant types are *automatically* exempt from ANCC, ACCME and NCHEC’s definition of a commercial interest**, including:

1. Blood banks, 2. Constituent Member Associations,

3. Diagnostic laboratories, 4. Federal Nursing Services,

5. For-profit and not-for-profit hospitals, 6. For-profit and not-for-profit nursing homes,

7. For-profit and not-for-profit rehabilitation centers, 8. Group medical practices,

9. Government organizations 10. Health insurance providers,

11. Liability insurance providers, 12. Non-health care related companies

13. Specialty Nursing Organizations

14. A single-focused organization\* devoted to offering continuing nursing education

15. National nurses organizations based outside the United States,

(\* The single-focused organization exists for the single purpose of providing CE)

**NOTE: 501c applicants are not *automatically* exempt.** The APHA/PHN Program requires 501c applicants to be screened for eligibility.

[ ]  **An "X" on this line identifies the applicant as exempt from ACCME or ANCC’s definition of a commercial interest. Identify the applicant's exemption type from section 2 above and enter it here:**

If you checked the box above, then you have completed this questionnaire, proceed to **Section 6.**

**Section 5 - Only complete this section if applicant organization is not exempt**

 [ ]  **An "X" on this line identifies the applicant as not exempt from the ACCME or ANCC CE Program’s definition of a commercial interest.** The following questions must be answered, so APHA /PHN can assess the applicant's eligibility.

* Does the applicant produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients?

[ ]  Yes **If yes**, the applicant is **not** eligible for approval of Individual Educational Activities.

[ ]  No **If no**, complete the next bulleted question

* Is the applicant owned or controlled by a multi-focused organization (MFO\*) that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

 [ ]  Yes **If yes,** complete the next bulleted question

 [ ]  No **If no, this section of the questionnaire is complete, proceed to Section 6.**

* Is the applicant a separate and distinct entity from the MFO\*?

 [ ] Yes - **If yes,** continue to section 5

 [ ]  No - **If no,** the applicant is **not** a separate and distinct entity from the MFO\* then the applicant is **not** eligible for approval of Individual Education Activities.

\* Multi-Focused Organization (MFO) is an organization that exists for more than providing continuing education.

**Section 6: Commercial Interest Evaluation**

* Does the multi-focused organization that owns the applicant have a 501(c) Non-profit Status?

[ ]  Yes [ ]  No **If no**, complete the next bulleted question

**If yes** does the company that owns the applicant advocate for a commercial interest (as defined by the ACCME, ANCC Accreditation Program?)

[ ]  Yes **If yes**, or not sure, please describe the relationship the applicant and/or company has with a commercial interest and the types of work the company that owns the applicant does for or on behalf of a commercial interest that might be considered advocacy.

[ ]  No

* Is any component of the multi-focused organization an entity that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

[ ]  Yes **If yes**, please describe the health care goods or service consumed by or used on patients and the role of the entity in producing, marketing, re-selling or distributing those healthcare goods or services.

[ ]  No **If no, this section of the questionnaire is complete, proceed to Section 7**.

If **yes**, please request, ***Individual Activity Eligibility Commercial Interest Addendum*** with this Form.

**Section 7: Statement of Understanding**

On behalf of (insert name of applicant), I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature on behalf of (insert name of applicant), that (insert name of applicant) will comply with all eligibility requirements and approval criteria throughout the entire approval period, and that (insert name of applicant) will notify the **APHA** promptly if, for any reason while this application is pending or during any approval period, (insert name of applicant) does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for activity approval shall be sufficient cause for the APHA/PHN Continuing Education Unit to deny, suspend or terminate (insert name of applicant)’s approval of this individual activity and to take other appropriate action against (insert name of applicant).

*(Eligibility Verification forms received without a signature incur a delay in processing which will cause a delay in the review of the individual education activity application.)*

An “X” in the box below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information contained.

[ ]  **Typed Signature (Required) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Completed By: Nurse (or Discipline Designated) Planner Name and Title and sign**

Please return the completed Eligibility Verification Form and, if necessary, the Individual Activity Eligibility Commercial Interest Addendum with this Form to APHA at: charlene.bright@apha.org

Approved by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Position: Accreditation Approver Program Director