



Individual Activity Application – NON-CLINICAL

Individuals and organizations can seek approval of individual educational activities to award CNE contact hours. Eligibility requirements must be met by the applicant, and educational design principles outlined in accreditation required criteria must be demonstrated in the application.

Educational activity content is considered **clinical** when focused on the diagnosis, treatment, nursing care and considerations of patients and/or patient populations. Potential to discuss healthcare products used by or on patients exist and relevant financial relationships with ineligible organizations/companies must be assessed and mitigated. If the activity meets clinical content definition, complete the CLINICAL application.

This application includes all documents and checklist of evidence to include, required to be completed by the applicant. See the NCNA website for additional resources <https://ncnurses.org/education/teach>

Complete applications should be submitted within 60 days of activity. For expedited applications, increase in fee will be applied. Contact the Accredited Approver Program Director with any questions or inquiries via email: ce@ncnurses.org

Required submissions to ce@ncnurses.org (checklist):

- Completed Individual Activity Application
- Timed agenda with contact hour calculation for activities longer than 3 hours
- Certificate/Document provided to learner, awarding contact hours
- Written disclosure or notification to learners of required information prior to the education

Provider Information

Name of Applicant Organization: Click or tap here to enter text.

Website (if applicable): Click or tap here to enter text.

Address: Click or tap here to enter text.

City: Click or tap here to enter text. State: Click or tap here to enter text. ZIP: Click or tap here to enter text.

Primary Contact Person:

Name: Click or tap here to enter text. Title/Position: Click or tap here to enter text. Email: Click or tap here to enter text.

Nurse Planner: *must be a registered nurse who holds a current, unrestricted nursing license AND hold a baccalaureate degree or higher in nursing AND be actively involved in the planning, implementing, and evaluation process of this NCPD education activity*

Name: Click or tap here to enter text. E-mail Address: Click or tap here to enter text.

Credentials (including degree(s) and license): Click or tap here to enter text. State licensed as RN/APRN

** The Nurse Planner is held accountable for ALL information provided on this application.*

Applicant Eligibility

The following section is intended to collect information about the applicant's corporate structure.

Is your organization one of the following? Check the box applicable:

- | | |
|--|---|
| <input type="checkbox"/> Ambulatory procedure centers | <input type="checkbox"/> Infusion center |
| <input type="checkbox"/> Blood banks | <input type="checkbox"/> Insurance or managed care company |
| <input type="checkbox"/> Diagnostic labs that do not sell proprietary products | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Electronic health record company | <input type="checkbox"/> Pharmacy that does NOT manufacture proprietary compounds |
| <input type="checkbox"/> Government or military agency | <input type="checkbox"/> Publishing or education company |
| <input type="checkbox"/> Group medical practice | <input type="checkbox"/> Rehabilitation center |
| <input type="checkbox"/> Health law firms | <input type="checkbox"/> School of medicine/nursing or health science university |
| <input type="checkbox"/> Health profession membership organization | <input type="checkbox"/> Software or game developer |
| <input type="checkbox"/> Hospital or healthcare delivery system | |

If you selected an option that applies, go to **Statement of Understanding** below.

Ineligibility Evaluation – complete this section if you **did not select** an organization above.

Companies are ineligible to provide accredited/approved education through the accredited approver of ANCC (ineligible companies) are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Does your organization produce, market, sell, re-sell, or distribute health care products used by or on patients (ineligible organization)?

- Yes **If yes**, the applicant is **not** eligible for approval of Individual Educational Activities.
- No **If no**, complete the next bulleted question **AND** provide a description of your organization/company.

Is your organization owned or controlled by an organization (ineligible) that produces, markets, re-sells, or distributes health care goods / services consumed by, or used on, patients?

- Yes **If yes**, contact ce@ncnurses.org to clarify eligibility of organization
- No **If no**, this section of the questionnaire is complete

Statement of Understanding

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

A typed name in the box below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information given

Completed by Nurse Planner name and **credentials**: Click or tap here to enter text.

Date: Click or tap to enter a date.

Individual Activity Application

Title of Activity: Click or tap here to enter text.

Total Number of Contact hours: Click or tap here to enter text.

Fee Amount Included: Click or tap here to enter text.

See [Teach - North Carolina Nurses Association \(ncnurses.org\)](http://ncnurses.org) to calculate fee – payment page at end of application

Activity Type:

- Live (in-person or virtual)
- Enduring material
- Blended activity with live and learner-paced components (pre-, during, or post-activity components)

LIVE ACTIVITY	ENDURING EDUCATION
Live activity type: <input type="checkbox"/> Course <input type="checkbox"/> Regularly scheduled series <input type="checkbox"/> Internet live course	Enduring activity type: <input type="checkbox"/> Internet activity <input type="checkbox"/> Journal-based CNE
Location of in-person activity, city & state: Click or tap here to enter text. <input type="checkbox"/> Or being held virtually	Describe how contact hours were calculated: Click or tap here to enter text.
Start date of activity: Click or tap to enter a date. End date of activity: Click or tap to enter a date.	Start date of activity: Click or tap to enter a date. Expiration date of activity: Click or tap to enter a date.

Activity Planning and Development

1. **Describe the professional practice gap** (describe what nurses currently know or can do in practice, including a change in practice, problem in practice, and/or opportunity for improvement): Guidance on description.
 - What is the problem or opportunity that needs to be addressed by this activity?
 - Provide a brief (1-2 sentence) explanation of the current problem.
 - Required CNE and description of the education does not describe the gap.
 - Example: *Nurses are not aware of new guidelines from CDC regarding adult immunizations.*

Click or tap here to enter text.

2. **Evidence to validate the professional practice gap/problem:** Provide a summary or describe how you know this professional practice problem or gap exist. Include Nurse Planner and Planning committee's analysis of the data.
 - How is the evidence (e.g., data, trends in literature) informing you that a professional practice gap exists for the target audience? What data supports the need for this education?
 - Stating that there is a "need" or a "request" for the activity is not adequate

Click or tap here to enter text.

3. **Educational need that is causing or underlies the professional practice gap:** (e.g., knowledge, skill and/or practice):
 - The underlying educational need should align with the professional practice gap. Simply knowledge, skills, or practice and supported by the gap description and desired learning outcome (below)
 - Reflecting on these questions:
 - Is the professional practice gap related to what they do not know (knowledge)?
 - Is the professional practice gap related to what they do not know how to do (skill)?

Check all that apply to the education content and learning outcome(s).

- Knowledge (identified gap that nurses do not know AND intend to measure nurses' knowledge during or at the conclusion of the activity)
- Skills (identified gap that nurses do not know how AND intend to measure nurses' skill during or at the conclusion of the activity)

4. **Target audience:** check all that apply

- RN &/or APRN (required)
- LPN/LVN
- CNA
- MD
- PA
- Social Worker(s)
- Other: (describe)

5. **Desired Learning Outcome:** A measurable outcome statement, states what the learner will know and/or know how to do at the end of the activity.

- The learning outcome statement needs to be written in measurable terms (quantifiable) and should include the outcome and the metric that the outcome is measured by.
- The learning outcome must tie to the professional practice gap and the underlying educational need. If the underlying need is knowledge, the outcome should be related to measuring a change in the learner’s knowledge, etc.
- ***The measurable learning outcome is NOT a list of objectives, NOR a number in front of an objective.***
- TIP: reflect on these questions to guide the NP/planning committee to choose the applicable learning outcome(s):
 - What is the measurable goal or outcome that this activity sets out to achieve?
 - *What should the learner(s) know, show, and/or be able to do at the end of the activity?*
 - What will be measured when the learner completes the activity?
 - Think SMART goal
- *Example:* 100% of nurses will accurately explain the CDC-recommended adult immunization protocol by answering questions in a case study at the conclusion of the activity.

Click or tap here to enter text.

6. **Evaluation method description:** Describe how you will collect evidence to show change in knowledge and/or skills at the end of the activity.

- The evaluation method chosen should align with the educational need(s) identified and the expected learning outcome(s) identified.
- An evaluation form is NOT required and may not measure knowledge as intended if list of objectives met with Likert scale of 1-5. Measuring intent to implement changes to nursing practice must be specific to their knowledge gained in the activity and include

open-ended response how/what they will implement.

- TIP: The description of the evaluation method should discuss how the evaluation data is obtained and analyzed and clearly describe the data being collected.
- *Example:* A case presentation will be led by faculty at the end of the activity. Learners will respond to questions built into the case by raising their hands/completing a questionnaire/responding on a response system. Faculty will assess that all (100%) learners correctly identified adult immunization protocols in the scenario.

Click or tap here to enter text.

7. **Description of evidence-based content:** description of the evidence-based content – outline, narrative description, abstract, and itemized agenda
 - For conferences and activities longer than 3 hours, an abstract can include a description of how the overall content facilitates learner achievement of the expected outcome for the conference, detailed information about individual sessions and individual session outcomes are not required.

Click or tap here to enter text.

8. **Supporting references or resources:**
 - Include best available evidence that appropriately supports the content of the education activity. Best practice if for the references and resources that have been developed and/or published within the last 5-7 years.
 - It is not required that references be provided in APA format, however references should include adequate detail to ensure that information referenced can be located (i.e., page number, date, author, publisher)

Click or tap here to enter text.

9. **Learner Engagement Strategies:** Describe strategies how the learner(s) will be actively engaged.
 - Congruent with activity format and the underlying educational needs identified above (knowledge and/or skill)
 - Do not describe teaching strategies such as lecture or slides.

Click or tap here to enter text.

10. Calculation of number of contact hours awarded: Describe and show contact hour calculation, including agenda if the activity is longer than 3 hours.

- Number of contact hours needs to be logical and defensible
- Documentation should include the number of contact hours and calculation method
- Rational for the number of contact hours calculated for enduring material must be described above (page 4)
- Provider must keep a record of the number of contact hours earned by each participant (this does not need to be provided in the activity file documentation)
- For activities over 3 hours (contact hours awarded), must provide a timed agenda with calculation.
- REMINDER: Rounding contact hours is permissible and encouraged. Provider may round up or down to the nearest ¼ (0.25) hour. Rounding must be realistic to the timed agenda.

Click or tap here to enter text.

11. Criteria for awarding contact hours: What is required of the learner to obtain their contact hour(s)?

- Should relate to the learning outcome(s) and be enforceable for the activity.
- Attendance criteria are mutually exclusive. For example, the learner cannot be expected to attend the entire education AND receive credit commensurate with participation.
- Criteria identified here MUST match disclosure/information provided to learners

Check ALL that apply:

- Attendance for entire education **OR** Credit awarded commensurate with participation
- Completion/submission of evaluation form (provide the evaluation items to measure knowledge in Evaluation Method)
- Successful completion of a post-test (attendee must score _____% or higher)
- Successful completion of a return demonstration

12. Documentation of completion and/or certificate of completion: Submit a sample certificate or documentation of completion transcript here. A sample certificate must include:

- Title and date of the educational activity

- Name and address of the provider of the educational activity (a web address is acceptable)
- Number of contact hours awarded to the learner
- Activity approval statement (*This nursing continuing professional development activity was approved by North Carolina Nurses Association - Approver, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. NCNA-XXXXXX-202X*) – activity number will be provided upon approval for this statement to be complete.
- Space for participant name

INSERT CERTIFICATE

Individuals in Control of Content & Support

Names and credentials of all individuals in a position to control content:

- In the table below, provide a complete list of individuals, clearly identify who is the **Nurse Planner** and who is the **Content Expert** serving on the planning committee.
- Provider **credentials** along with the names of the individuals, including education and licensure.
- The list must include ALL individuals with the ability to control content.

Name of Individual and CREDENTIALS	Individual's role in activity	Planning committee member? (yes/no)

Commercial Support: Activities that choose to accept commercial support (defined as financial or in-kind support from ineligible companies) are responsible for ensuring that the education remains independent of the ineligible company and that the support does not result in commercial bias or commercial influence in the education. The support does not establish a financial relationship between the ineligible company and planners, faculty, and other in control of content of the education.

Key elements must be submitted in the fully executed (signed and dated) agreement and maintained in the file:

- Appropriate management of commercial support, if applicable
- Maintenance of the separation of promotion from education, if applicable
- Promotion of improvements in health care and NOT proprietary interests of a commercial interest.

Is this activity receiving commercial support? *If commercial support is being given to a jointly provided activity, the primary provider organization (applicant) must manage all funds received*

No Yes* -- Include a signed commercial support agreement with application

Name of commercial supporter: Amount of money received OR type of in-kind contribution provided:

Required disclosed information to learners

Required disclosures to Learners: MUST BE INCLUDED IN APPLICATION.

- Evidence of what is required information must be provided to learners prior to the start of the educational activity (REQUIRED 1 & 2; other disclosure information as applicable)
 - Evidence MUST be in writing (NCNA criteria)
 - Include relevant slide(s), screen shot(s), or other evidence showing what the learners will receive and when they will receive the information
1. **Activity approval statement** as issued by the Accredited Approver (NCNA): Should be consistent with the statement provided by the Accredited Approver upon approval of activity and should match the approval statement on the sample certificate or document of completion:
 - **No** mention of approval prior to submitting application.
 - With this application submission, include the following statement:

This activity has been submitted to North Carolina Nurses Association – Approver for approval to award contact hours. North Carolina Nurses Association – Approver is accredited as an approver of nursing continuing professional development by the American Nurses Credentialing Center’s Commission on Accreditation. ANCC Approver A0141.

- If the advertising is to be released **after approval** is received, then use the following statement:

This nursing continuing professional development activity was approved by North Carolina Nurses Association – Approver, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. ANCC Approver A0141.

2. **Criteria for awarding contact hours** as stated above in the application and consistent with the planning process

IF APPLICABLE, Commercial support from ineligible organization/companies:

- Names of the ineligible companies that gave support and the nature of the support.
- NO logos, trade names, or product group messages for the organization can be provided in the disclosure
- If no commercial support received, do not say anything about support

IF APPLICABLE, Expiration date for enduring activity

IF APPLICABLE, Joint providership: Occurs when 2 or more groups collaborate to develop an educational activity. The individual activity applicant is responsible for ensuring adherence to ANCC/NCNA educational design criteria. Individual activity applicant name should be clear, and the activity approval statement as issued by NCNA must be on the certificate and disclosure. It should be clear that the approved activity organization is providing the contact hours.

- Statement that demonstrates that 2 or more groups were involved in planning and development of the activity
- There is no prescribed statement that must be used.

INSERT WRITTEN DISCLOSURE TO LEARNERS

If you wish to pay by credit card you can use this form to submit credit card information. This page will be deleted from the PDF file, once the payment has been charged and validated.

If you prefer, you can call NCNA at 919-821-4250 to give payment information by phone.

Payment for Individual Educational Activity Application

APPLICATION INFORMATION

Name of Activity: _____

Nurse Planner Name: _____

Start Date: _____

PAYOR INFORMATION

Name of Payor: _____

Phone for Payor: _____

Email for Payor: _____

Mailing Address for Payor: _____

CREDIT CARD INFORMATION

Credit Card Type: Visa MC

Card Number: _____

Card Expiration Date: ____/____

Billing Zip Code: _____

Name as it appears on the card: _____

\$ amount to be charged: \$_____