

CNE-Net Use Only / Approver Unit
Approved Provider Number:

**2008 CNE-Net™
Approved Provider Application**

Name of Organization: _____

Type of Organization: Hospital Health System Clinic
 Long Term Care Other: _____

Mailing Address: _____
(this address will be used for all mailings)

Contact Person: _____ Role in Provider Unit: _____

Credentials and Title: _____

Email: _____ Phone: _____ Fax: _____

Primary Nurse Planner: _____

Has your provider application been denied by another ANCC accredited Approver?
Yes _____ No _____ Explain _____

Type of Activities Planned: Provider Directed Learner Directed

Website: _____

CNE-Net Use Only

Application Received: _____
Date

Payment Received:

Date: _____ Amount Paid: _____ Amount Due: _____

Approved: _____

Approved Provider Status expires: _____ (3 years from date of approval)

Deferred: _____ Date Not Approved: _____ Date

Peer Reviewer Signature: _____

Applicant Notified: Phone Fax Email Cover Sheet Mailed _____
Sent by

Criteria	Reviewer use only Criteria Met: Circle Yes or No	Reviewer Comments
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I. Goals and Organization	Yes(Y) No(N)	
<p>1. Organization</p> <p>a. Describe the Approved Provider Unit and the parent organization (if applicable):</p> <ul style="list-style-type: none"> ■ Who is included in the unit ■ Who carries out the functions of the unit ■ Target audience ■ Service area 	<p>a. Y N</p>	
<p>2. Goals</p> <p>a. Goals are identified for the Approved Provider Unit and include a clear description of their linkage with the parent organization (if applicable) and are included in this application as page(s) _____.</p> <p>b. The Provider Unit's beliefs /philosophy are included in this application on page_____.</p>	<p>a. Y N</p> <p>b. Y N</p>	
<p>3. Organizational Chart</p> <p>a. Organizational chart or description of the Approved Provider Unit and its relationship to the overall organization included in this application as page _____.</p> <p>Include name(s), title(s), and credential(s) of each individual</p>	<p>a. Y N</p>	

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II. Unit Operations/Educational Design Criterion	Yes(Y) No(N)		
<p>1. Primary Nurse Planner</p> <p>a. Primary Nurse Planner Name, Degree(s), Credential(s): (Baccalaureate degree or higher, one of which must be in nursing, is required)</p> <p>Current Position Title:</p> <p>Phone: _____ Fax: _____</p> <p>Email: _____</p> <p>b. Biographical Data Form for Primary Nurse Planner included in application on Page _____. (DO NOT submit resumes or CV's)</p> <p>If additional Nurse Planners are utilized, name(s), degree(s), credential(s) here: Minimum of a baccalaureate degree or higher, one of which must be in nursing, is required.</p> <p>c. Biographical Data Forms for all Nurse Planners included in application on page(s) _____. (DO NOT submit resumes or CV's)</p> <p>d. All Nurse Planners are kept up to date with ANCC by: <input type="checkbox"/> Orientation meeting <input type="checkbox"/> Read-share emails/newsletters from CNE-Net <input type="checkbox"/> Update all internal documents as appropriate <input type="checkbox"/> Other: Describe _____</p>	<p>1.</p> <p>a. Y N</p>		
	<p>b. Y N</p>		
	<p>c. Y N</p>		
	<p>d. Y N</p>		

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<p>2. Assessing Needs, Planning, Implementation, and Evaluation (Describe the process for assessing, planning, Implementing, and evaluating nursing CE. Include personnel and their role(s) Page _____.</p> <p>a. Needs Assessment (check methods used to assess need for continuing nursing education activities)</p> <p><input type="checkbox"/> Formal Needs Assessment <input type="checkbox"/> Quality Assurance Activities</p> <p><input type="checkbox"/> Education Committee <input type="checkbox"/> Previous Evaluations</p> <p><input type="checkbox"/> Literature Review <input type="checkbox"/> Survey</p> <p><input type="checkbox"/> Patient Care Requirements <input type="checkbox"/> Analysis of Patient Population</p> <p><input type="checkbox"/> Other: (describe)</p> <p>b. Planning and Implementation(initial to verify compliance)</p> <p>_____ All activities are planned and implemented according to ANCC criteria, as supplied by CNE-Net</p> <p>_____ Operational Requirements for Approved Providers will be implemented throughout the approval period. Signed attestation statement is included in this application on page _____.</p> <p>_____ Sample of certificate of successful completion to be used as an Approved Provider is included in this application on page _____.</p> <p>_____ Sample of individual contact hour application form to be used is included in this application on page _____.</p> <p>All communications, marketing materials, certificates will contain the official accreditation state as follows:</p> <p>(Name of Approved Provider) is an approved provider of continuing nursing education by CNE-Net, the education division of the North Dakota Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.</p> <p>This statement cannot be abbreviated and must stand alone.</p>	<p>2.</p> <p>a. Y N</p> <p>b. Y N</p>	
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<p>c. Disclosures: Learners shall receive the following information regarding each activity: Initial</p> <p>_____ Notice of requirements for successful completion</p> <p>_____ Learners/participants are informed of any conflicts of interest or lack thereof disclosed by planners or presenters</p> <p>_____ Learners/participants are informed of any commercial support related to the activity</p> <p>_____ Learners/participants are informed of non-endorsement of products</p> <p>_____ Learners/participants will be informed of any off-label product use</p> <p>_____ ACCME standards for disclosure and commercial support reviewed by Nurse Planners (Appendix_____)</p>	<p>c. Y N</p>	
<p>d. Describe how Approved Provider Unit responsibilities are assigned and maintained for c0-provided/co-sponsored activities if any:</p>	<p>d. Y N</p>	
<p>e. Evaluation: Initial</p> <p>_____ Evaluation is completed for each activity, summarized, filed for four years, and used to improve quality of that or future activities</p>	<p>e. Y N</p>	

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(DO NOT submit resumes or CV's)	Yes(Y) No(n)	
<p>2. Material Resources (initial appropriate lines to indicate availability)</p> <p>_____ Office space with appropriate furniture, file cabinets, computers, etc.</p> <p>_____ Audiovisual equipment or ability to rent equipment</p> <p>_____ Room space for live presentations</p> <p>_____ Ability to contract with outside organizations for room space</p> <p>_____ Other: (please describe)</p>	<p>2. Y N</p>	
<p>3. Financial Resources</p> <p>a. Sources of support (initial all that apply)</p> <p>_____ Allotted budget from parent organization</p> <p>_____ Fees from events</p> <p>_____ Educational grants</p> <p>_____ Other: (please describe)</p> <p>b. Continued support (initial to verify compliance)</p> <p>_____ This organization expects to be able to provide continued financial support for maintenance of the Approved Provider Unit through the projected approval period. Briefly describe how financial support is projected throughout the three-year period.</p>	<p>4. a. Y N</p> <p>b. Y N</p>	

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<p>c. The Approved Provider Unit must adhere to all state and federal regulations and legal and ethical considerations as they relate to human resources and financial and legal obligations</p> <hr/> <p>Signature of Primary Nurse Planner</p>	<p>c. Y N</p>	
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IV. Evaluation Criterion

<p>1. Comprehensive Approved Provider Unit Evaluation Plan a. Describe the Approved Provider Unit evaluation which is a systematic, ongoing process and evaluates the following: a) administrative and operational procedures b) array of continuing nursing education activities c) outcomes and results d) quality improvement processes; included in this application on page_____.</p>	<p>1. Y N</p>	
<p>2. Describe how the evaluation data were used to confirm, expand, and/or change Approved Provider Unit operations over the past three years; included in this application on page(s) _____.</p>	<p>2. Y N</p>	
<p>3. Describe how nurse planners, presenters/content specialists, learners/participants, and approved Provider Unit staff participate in the overall evaluation process.</p>	<p>3. Y N</p>	
<p>4. Describe how the Approved Provider Unit's goals over the past three years have been addressed, the progress made, and new goals that have been identified.</p>	<p>4. Y N</p>	

**APPROVED PROVIDER UNIT
APPLICANT CHECKLIST**

BEFORE SUBMITTING THE APPLICATION TO CNE-Net, PLEASE CHECK IT FOR COMPLETENESS AND ACCURACY TO ASSURE TIMELY APPROVAL OF YOUR ACTIVITY.

_____ Completed Approved Provider application

_____ *Biographical Data Forms:

Primary Nurse Planner

All other persons involved in the Approved Provider Unit

*Includes declarations of Conflict of Interest and Off-label or Investigative drug usage discussion.

_____ Signed Operational Requirements Attestation(s) for each Nurse Planner

_____ Sample Certificate of Successful Completion

_____ Sample of completed Continuing Nursing Education Contact Hour Application

_____ Sample of Co-provider Agreement

_____ Three examples of continuing nursing education activities implemented by the Approved Provider Unit (Include summaries of evaluations)

_____ Appropriate fee

2008 Fee Schedule:

\$1,250.00 for three year approval period (Fee must be received with application)

Please allow a minimum of six weeks for processing of your application.

Mail completed application and all supporting materials to:

CNE-Net

531 Airport Road, Suite D

Bismarck, North Dakota 58504