**APPLICATIONS:**

* This application is for activities that will not receive continuing education contact hour credit, but will be entered into attendees UCLearning transcript.
* For assistance/questions call or visit the Center for Professional Practice of Nursing office, 4900 Broadway, Suite #1630, (916) 734-9790.

Required Form Information:

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|  | **Title of Educational Activity:** Should be specific to content. If Activity is part of a series of an ongoing program, precede specific class title by series name; i.e., IV Catheter Placement Inservice. |
|  | **Date(s) and Time of Activity**: Planned date(s) and time(s) |
|  | **Target audience:** Who is the activity directed to (All inpt RN’s, PT and OT providers) |
|  | **Application submitted by:** Completed by the coordinator of the class |
|  | **Goal for overall Activity:**  Stated purpose or Activity description and expectation **(**i.e., To inservice staff on *new product name* for timely and safe use.) |
|  | **Education Provided by**: Names, degrees, certifications, titles, of person(s) providing education |
|  | **Education Provided through:** How the education is to be provided i.e., demonstration with return demo, educational flyers, product handout. (All printed materials need to be submitted with application) |

***Activities are approved for three years and may be re-offered at any time during that period.***

**CPPN will provide inservice rosters**

* Upon return of rosters data will be entered into UCLearning, and educational materials will be maintained electronically for ***three years after the date of the last offering***.

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| **Title of Activity:**  Click here to enter text. | | |
| **Type of Activity:** Click here to enter text.  Staff Inservice  Skills Day/Inservice Other: *(Describe)* | | |
| **Location:** Click here to enter text. | | |
| **Start Date:** Click here to enter a date. | | **End Date:** Click here to enter a date. |
| **Expected Time Length:** Click here to enter text. | | |
| **Maximum # participants for Activity:** Click here to enter text. | | |
| **Target Audience include Unit/job title:** Click here to enter text. | | |
| **Goal/Purpose of Activity:** Click here to enter text. | | | |
| **Submitted By *(Name, Degree, Cred, Titl*e):** Click here to enter text. | | | |
| **Department:** Click here to enter text. | | | |
| **Telephone:** Click here to enter text. | **Email Address:** Click here to enter text. | | |
| **Check if requesting Rosters for specific Unit(s)**  **List Unit(s):** Click here to enter text. | | | |
| For CPPN Office Use Only | | | |
| Application reviewed and meets criteria.  Center for Professional Practice of Nursing | | | |
| Date received: Click here to enter a date.  Approval date: Click here to enter a date.  Renewal date: Click here to enter a date.  Course Code: Click here to enter text. | | | |

| **Title of Activity:** Click here to enter text. | | | | |
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| **Content (Topics)**   * Provide a short outline of the content/skill/topic presented and/or National Safety Goal or Nursing Quality Indicator Addressing (See attached List) * List any Handouts that will be provided * ***Insert additional row for each topic/session.*** | **Objectives**   * List the educational objectives * Behavior/performance objectives are stated in terms of what the student or learner will do, rather than what the instructor will do. | **Time Frame**   * In Minutes | **Presenter**   * List person responsible for information related to specific content/skill/topic | **Teaching Strategies**   * List the teaching strategies for each skill, topic or content area. |
| EVD lumbar drainage system review  Example Example Example | Demonstrate how to prime an EVD system. | 15 min | Tish Campbell, RN-BC | Skill review with return demonstration of skill. |
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