

Show name and address where
reply should be sent if different
from that shown below:

FOR OFFICE USE ONLY

APPROVED ____ hrs.
CE Credit
DATE: _____

Date
Received _____

BY: _____
Continuing Education
Advisory Task Force

MINNESOTA BOARD OF PHARMACY, 2829 University Ave. SE, #530, Minneapolis, MN 55414 (651) 201-2825

CONTINUING EDUCATION PROGRAM APPROVAL FORM

DESCRIPTION: The program provider is directed to follow the guidelines in completing this form. Incomplete forms may be returned for further information delaying program reviewal and reply. To receive credit, the form must be submitted prior to the program/course.

1. Name and address of organization or individual seeking approval: _____
_____ 1A) Date of application _____

2. Name & address of individual responsible for continuing education program where this differs from #1: _____

3. As a program provider do you agree to:	YES	NO
(a) maintain attendance records for this program?	_____	_____
(b) include name and address of participants on attendance records?	_____	_____
(c) maintain attendance records so that % completion or hours completed will be shown?	_____	_____
(d) provide evidence to each participant of satisfactory completion of the program?	_____	_____
(e) make such attendance records available on request to participants or board for three years after completion of program?	_____	_____

4. Do you agree to:		
(a) maintain description of content of this program?	_____	_____
(b) make program description available to participant or board for three years after completion of last program presentation?	_____	_____
(c) submit a copy of a summary of the evaluation results if requested to do so?	_____	_____

5. PROGRAM TITLE: _____

6. DESCRIPTION OF PROGRAM:
(a) Program site(s): _____
(b) Program date(s) where applicable: _____
(c) Number & length of program units (where applicable) _____
(d) Type: (seminar, corres., etc.) _____
(e) Duration of total program:
(for seminar, study group, etc.) _____ contact hours
(for self-study programs) _____ estimated study time
(f) Nature of audience for whom program prepared _____

(g) Number of participants anticipated: _____

7. Was a needs assessment done? Yes No
 If yes, indicate how the educational needs were assessed in the planning for this program by checking the appropriate blank:
 A survey conducted among potential clientele.
 The program was planned with pharmacist representatives.
 Other methods were employed. Please describe briefly.

8. Program Goals: _____

9. Program Learning Objectives: _____

10. How will the program be presented? (e.g., Lecture, panel, discussion group, workshop, group study session, private study, etc.)

11. What types of audio/visual aids will be used? (Please check those which are applicable.)
 Slides Films Video tapes Charts
 Exhibits Audio cassette tapes Other (describe) _____
12. Will program outlines be made available to participants? Yes No
13. Will case histories be used in the program? Yes No
14. Will an annotated reading list be made available? Yes No
15. PROGRAM FACULTY & QUALIFICATIONS:
 Name: _____ Position: _____

16. Describe the methods to be used in evaluation of this program in terms of procedures,

17. OTHER INFORMATION WHICH YOU MAY WISH TO RELATE: _____

18. Please enclose promotional brochures, program schedule, materials, outlines, etc.

Person completing this form/title

Telephone number

Please return this completed form to:

Cody C. Wiberg
 Executive Director
 MN Board of Pharmacy
 2829 University Ave. SE, #530
 Minneapolis, MN 55414-3251
 Phone (651) 201-2825