### **Before you submit your CNE application**

The ENA CNE Approver Unit welcomes consulting with nurse planners. If you would like to discuss any issues you may have while planning or following a CNE activity with ENA’s Nurse Peer Review Leader please take the opportunity to propose times to schedule a conference call by contacting CNE@ena.org.

1. The application is a planning document. Use it as a guide when planning your educational activity for the entirety of the offering, whether it is one hour or three days.
2. Education of nurses is a continuing process and CNE is intended to improve their knowledge, skills and/or practice. Design your activity with the purpose of changing and/or improving nurses professional development. Identify the problem, plan the implementation, and measure the accomplishment using evidence that addresses the problem.
3. As the nurse planner, you are accountable to ENA to assure that all ANCC accreditation criteria are met. Nurse planners lead the preparation of the adult learning activity by recognizing that the problem identified has the best available evidence to make a change and/or improvement with no bias by those involved. You want to be able to identify and document the problem learners will know or do better or differently after your educational activity.

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| **1.0 CNE Application (Individual Educational Activity)****Emergency Nurses Association—Accredited Approver** *(2015 Criteria)* |
| *ENA Office Use Only—Activity Code:*  |

*ENA is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.*

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| **1.1 Application Category** (*Choose* ***one*** *of the below categories*) (*business address or web address will appear on certificate of completion)* |
| **ENA Chapter or State Council:** | [x]  Yes [ ]  No  | **Non-ENA Applicant:** | [ ]  Yes [ ]  No  |
| Applicant/Organization Name: (that will appear on marketing materials and certificate) |  | Applicant/Organization Name: (that will appear on marketing materials and certificate) |  |
| Business Address (or Web Address): |  | Business Address (or Web Address): |  |
| City/State/Zip:  |  | City/State/Zip: |  |

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| **1.2 Applicant Eligibility** [(Click here to review the ANCC Content Integrity Standards)](https://www.nursingworld.org/~48cec7/globalassets/docs/ancc/accred-cecontentintegrity.pdf) |
| 1. Is this organization a **commercial entity** as defined by ANCC?
 | [ ]  Yes [ ]  No |
| If **yes** to (A), please **STOP**! Commercial interest organizations are not allowed to provide CNE activities. |
| 1. Is this continuing education? Is this learning activity intended to build upon the educational and experiential bases of the professional RN for the enhancement of practice, education, administration, research, or theory development, to improve the health of the public and RNs’ pursuit of their professional career goals?
 | [ ]  Yes [ ]  No |
| If **no** to (B), the activity is **not** eligible for approval.  |

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| **1.3 Nurse Planner and Primary Contact Information** |
| *The* ***Nurse Planner*** *must be a registered nurse who holds a current, unencumbered nursing license (or international equivalent)* ***AND*** *holds a baccalaureate degree or higher in nursing (or international equivalent)* ***AND*** *be actively involved in planning, implementing and evaluating this continuing education activity. There should only be one Nurse Planner per application.* |
| Nurse Planner Name  |  |
| Credentials (Must have a minimum of a baccalaureate degree in nursing) |  |
| State(s) in which licensed as an RN: |  |
| Email Address: |  |
| Phone Number:  |  |
| Alternate Phone Number:  |  |
| *Complete below if* ***someone other than the activity Nurse Planner is the primary point of contact*** *for correspondence related to this application.* |
| Point of Contact Name: |  |
| Email Address: |  |
| Phone Number: |  |
| Alternate Phone Number: |  |

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| **1.4 Activity Information** |
| Title of Activity: (Name that will appear on marketing materials and certificate)  |  |
| Address where activity will be offered (City, State): |  |
| How many times will this program be offered?*\*Continuously Repeated Activities: The continuously repeated program must maintain the same content, speakers, outcomes, and professional practice gap during approval.* *Contact Approver Unit if you have questions.* | [ ]  Once [ ]  Repeated “X” times for a 1 or 2-year approval period\* |
| 1. ***Activity Type*** *(choose* ***one*** *of the below four options)*
 |
| 1. Provider-directed, provider-paced: *Live* (real-time)
 | [ ]  | Date(s) of live activity: |  |
| 1. Provider-directed, learner paced: *Enduring Material* (ex. Webinar, Independent study)
 | [ ]  | Start date of enduring material:  |  |
| Expiration/end date of enduring material: |  |
| 1. Learner-directed, learner-paced: *Enduring material (Learners must be informed of expiration date)*
 | [ ]  | Start date of enduring material: |  |
| Expiration/end date of enduring material: |  |
| 1. Blended Activity: Live and Learner-paced *(ex. Read an article prior to attending activity where it will be discussed. Number for each component)*
 | [ ]  | Date(s) and amount of prework and/or post-activity work: (e.g. prework) |  |
| Date and amount of live portion of activity: |  |
| 1. ***Contact Hour Calculation***
 |
| *Contact hour calculation is based upon a* ***60-minute contact hour.*** *Contact hours can be calculated to the tenth or hundredth place but cannot be rounded up. For example, if your program is 75 minutes, dividing by 60 gives you 1.25. (Click here to view* [ENA Fee Schedule*,*](https://www.ena.org/docs/default-source/education-document-library/cnefeeschedule.pdf?sfvrsn=82c4740b_2) *the ENA Approver Unit will invoice the nurse planner with the approval documents, based on total contact hours submitted.)*  |
| **Total** number of contact hours calculated: |  |
| ***If applicable****, are there multiple concurrent sessions?*  | [ ]  Yes [ ]  No |
| *If yes to the above, what is the* ***maximum*** *number of contact hours an attendee can earn (this value should be less than the total number of contact hours)? Or indicate N/A.* |  |
| *OR* [ ]  *N/A* |
| Designations (*optional*): *Click here to review information on* [Designations](https://www.ena.org/docs/default-source/education-document-library/designationsdefinitionspharmacologyguidelines.pdf?sfvrsn=9cd78036_2)*and Guidelines for Pharmacology**Designations do not have to equal number of contact hours. Please enter a* ***numerical*** *value.* If you are seeking designations or have concurrent sessions, please complete the provided[4.0 Contact Hour Matrix Worksheet.](https://www.ena.org/docs/default-source/education-document-library/4-0contacthourmatrix.doc?sfvrsn=d70aabc2_2) | Clinical: |  |
| Pediatrics: |  |
| Trauma: |  |
| Pharmacology: |  |

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| **1.5 Gap Analysis/Needs Assessment**[(Click here to view Professional Practice Gap and Learning Outcome Examples)](https://www.ena.org/docs/default-source/education-document-library/professional-practice-gap-and-learning-outcome-examples.pdf?sfvrsn=8292c8eb_2) |
| 1. ***Description of the target audience*** *(can select more than one re: who problem affects/needs the education, look at team-based learning)*
 |
| [ ]  | All Emergency Department RNs |
| [ ]  | All RNs |
| [ ]  | Advanced Practice RNs |
| [ ]  |  RNs in Other Specialty Areas (*Identify specialty*):  |
| [ ]  |  LPNs |
| [ ]  |  Interprofessional—*Describe*:  |
| [ ]  |  Other—*Describe*:  |
| 1. ***Description of the professional practice gap*** *(e.g. change in competence, change in performance and/or change in patient outcomes)*
 |
| Describe the current state:(*What is it that nurses are not currently doing or not doing that they could or**should be doing)*  |  |
| Describe the desired state:*(Difference between**what learners**currently know, have**the ability to do, or perform in practice**compared to what**they should know,**have the ability to do or perform in practice)* |  |
| Describe identified gap *(describe overall purpose of activity)* |  |
| 1. ***Choose educational need(s) that underlies the professional practice gap*** *(e.g. knowledge, skills and/or practice)*

*What needs to happen first in order to improve this situation (i.e., know something, perform better, use what they know and do in practice setting) Select need(s) that matches goal of activity* |
| [ ]  | Gap in Competence (*knows*) |
| [ ]  | Gap in Performance (*knows how*) |
| [ ]  | Gap in Patient Outcomes  |
| [ ]  |  Other—Describe:  |
| 1. ***Evidence to validate the professional practice gap*** *(check all methods/types of data that tells you that this is a problem, why it exists)*
 |
| [ ]  | \*Survey data from stakeholders, target audience members, subject matter experts or similar |
| [ ]  | Input from stakeholders such as learners, managers, or subject matter experts |
| [ ]  | Evidence from quality studies and/or performance improvement activities to identify opportunities for improvement |
| [ ]  | \*Evaluation data from previous education activities |
| [ ]  | Discussions with other healthcare professionals, colleagues |
| [ ]  | Trends in literature, law and health care |
| [ ]  | Direct observation |
| [ ]  |  Other—Describe:  |
| \*In reference to data, please provide a brief summary of data gathered that validates the need for this activity: |  |

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| **1.6 Learning Outcomes** |
| Desired learning outcome(s):*What will the outcome be as a result of participation in this activity?**Describe in terms reflecting changes in competence, performance and/or patient outcomes* *You have the option of including a global outcome or outcomes for individual sessions.* |  |
| ***Area of impact*** *(check all that apply)* |
| [ ]  | Nursing Professional Development |
| [ ]  | Patient Outcome |
| [ ]  |  Other—*Describe*:  |
| Outcome Measure(s) (*A quantitative statement as to how the outcome of this activity will be measured*):*What do you want learners to know or be able to do at the end of this activity?**A gain in knowledge, successful demonstration of a skill?* *How will the educator measure – show an improvement or change.**The activity Evaluation Tool is NOT to be used to identify Learning Outcomes* |  |
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| **1.7 Content of Activity** (*submit the required* 3.0 Education Planning Table *for all educational session(s*)) to meet the requirements for educational design. You can use one Education Planning Table to compile all sessions into a single table or use separate tables. |
| 1. ***Content for this activity was chosen from*** *(check all that apply) Use current, best-available evidence supporting content*
 |
| [ ]  | Information available from the following organization/website (organization/web site must use currently available evidence within the past 5-7 years as a resource for readers; may be published or unpublished content; examples—Agency for Healthcare Research and Quality, Centers for Disease control, National Institutes of Health |
| [ ]  | Information available through peer-reviewed journal resources (reference should be within past 5-7 years) |
| [ ]  | Clinical guidelines (example: www.guidelines.gov)  |
| [ ]  | Expert resource (individual, organization, educational institute) (book, article, website):  |
| [ ]  | Textbook reference |
| [ ]  | Other—*Describe*:  |
| 1. ***Learner engagement strategies*** *(check all that apply)* *How will learners be actively engaged in the educational process (Q&A, group work)*
 |
| [ ]  | See education planning table OR |
| [ ]  | Integrating opportunities for dialogue or question/answer |
| [ ]  | Including time for self-check reflection |
| [ ]  | Analyzing case studies |
| [ ]  | Providing opportunities for problem-based learning |
| [ ]  | Other—*Describe*:  |
| **1.8 Criteria for Awarding Contact Hours—criteria for awarding contact hours for live and enduring material include:** *(check all that apply). The below selections must be listed on your* 5.0 Disclosure Handout. |
| [ ]  | Attendance for a specified period of time (e.g., 100% of activity, or miss no more than 10 minutes of activity) |
| [ ]  | Credit awarded commensurate with participation |
| [ ]  | Attendance at 1 or more sessions (*pro-rating total contact hours*) |
| [ ]  |  Completion/submission of evaluation form |
| [ ]  |  Successful completion of a post-test (e.g., attendee must score      % or higher) |
| [ ]  |  Successful completion of a return demonstration |
| [ ]  |  Other—*Describe*:  |
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| **1.9 Evaluation of Activity:** *How will change in competence, performance, and/or practice be evaluated at the end of this activity? (Refer back to* ***identified practice gap*** *and* ***educational need****—evaluation MUST occur at the level of need identified in* ***1.5 C*** *above)* |
| Description of evaluation method:  |  |
| 1. ***Short-term evaluation options*** *(check all that apply)*
 |
| [ ]  | Intent to change competence |
| [ ]  | Active participation in learning activity |
| [ ]  | Post-test |
| [ ]  |  Return demonstration |
| [ ]  |  Case study analysis |
| [ ]  |  Role-play |
| [ ]  |  Other—*Describe*:  |
| 1. ***Long-term evaluation options*** *(check all that apply)*
 |
| *Long-term evaluation implies a method/process to follow-up with the attendees at an identified time interval following the activity. This can be done in various ways. ENA has a follow-up survey which will be provided after the required documents are sent to ENA* . |
| [ ]  | Self-reported change in performance  |
| [ ]  | Change in patient outcomes |
| [ ]  | Change in quality outcome measure |
| [ ]  | Return on Investment (ROI) |
| [ ]  |  Observation of performance |
| [ ]  |  Other—*Describe*:  |
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| **1.10 Commercial Support**  |
| Did this activity receive commercial support? If yes, please submit [6.0 Commercial Support Agreement](https://www.ena.org/docs/default-source/education-document-library/6-0commercialsupportagreement.docx?sfvrsn=5cdb4e71_2)*If this activity will have commercial support—you must disclose to learners* |  [ ]  Yes [ ]  No  |

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| **1.11 Certificate/Evaluation/Roster** |
| *If you are using ENAs forms, please select “yes” below. These forms will be provided to you in your CNE approval email. If you select* ***no*** *to using ENAs provided* ***certificate****, you must submit a copy of with your application. Contact the ENA Approver Unit if you have questions about these documents.*  |
| Certificate and/or documentation of completion **must** include the following:* Title and date of activity
* Name and address of provider (applicant) of activity (web address is acceptable)
* Activity Address (*if* *live*)
* Number of contact hours awarded
* Approver statement (see attachment 8 on required attachments)
* Participant name
 | ***I will use ENAs provided certificate:*** | [ ]  Yes [ ]  No  |
| *Optional*—Post course evaluation | ***I will use ENAs provided evaluation:***  | [ ]  Yes [ ]  No  |
| *Optional*—Participant roster* The provider must keep a record of the number of contact hours earned by each participant, through a unique identifier.
 | ***I will use ENAs provided roster:*** | [ ]  Yes [ ]  No  |

***Please be sure to complete the following pages before submitting this application***

*\*Completion of Attachment 1 on following page*

*\*Review of* ***required attachments*** *to submit with 1.0 Application*

*\*Completion of Nurse Planner attestation on last page*

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| **Attachment 1—Individuals in a Position to Control Content** |

Complete the table below for ALL individuals (Nurse Planner, Content Expert, Presenters, etc.) in a position to control content of the educational activity and include name, credentials, educational degree(s), and role on the planning committee (*if applicable*). There must be one Nurse Planner and one other planner to plan each educational activity. **The Nurse Planner should be knowledgeable of the CNE process and is responsible for adherence to the ANCC criteria.** One planner needs to have appropriate subject matter expertise for the educational activity being offered (Content Expert).

**The individuals who fill the roles of Nurse Planner and Content Expert must be identified. There should only be one Nurse Planner per CNE application.**

*Names and credentials of all individuals in a position to control content (must identify the individual who fill the roles of Nurse Planner and content expert(s).*2.0 Conflict of Interest *form* ***must*** *be submitted for all individuals listed below. These individuals must also be listed on* 5.0 Disclosure Handout.

|  |  |  |  |  |
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| **Name of individual and credentials** | **Individual’s role in activity** | **Planning committee member? (Yes/No)** | **Name of commercial interest** | **Nature of relationship** |
| *Example: Jane Smith, RN-BC* | *Nurse Planner* | *Yes* | *None* | *N/A* |
| *Example: Sue Brown, RNC* | *Content Expert* | *Yes* | *None* | *N/A* |
| *Example: John Doe, PhD* | *Presenter* | *No* | *Pfizer* | *Speakers Bureau*  |
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*Tip: If additional fields are required, right click on table below 🡪 select insert 🡪 select insert rows above/rows below*

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| **Required Attachments (*Checklist*)** |

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| **Please provide evidence of the following attachments** [(forms referenced below are hyperlinked and available on the ENA website)](https://www.ena.org/education/cne-application-and-approval-process)Remember to do the following before you submit your CNE application to CNE@ena.org**:** * Follow consistent file naming conventions, such as ***2.0 Conflict of Interest\_Jones***, ***2.0 Conflict of Interest\_Smith***, **3*.0 Education Planning Table\_Jones***, etc.
* Keep all application documents in their original Word format, (*do not hand write on forms, save word docs as PDFs, scan or fax*).
* Do not hesitate to contact the ENA Approver Unit if you have any questions about what needs to be submitted.
 |
| **Attachment 1** | Names and credentials of all individuals in a position to control content (must identify the individual who fill the roles of Nurse Planner and Content Expert(s).*(see previous page to complete* ***Attachment 1****)* |
| **Attachment 2** | **Conflict of interest** documentation from all individuals in a position to control content (e.g. planners, presenters, faculty, authors, and/or content reviewers) and resolution if applicable.[(2.0 Conflict of Interest Form)](https://www.ena.org/docs/default-source/education-document-library/2-0conflictofinterest-approver.docx?sfvrsn=d5df8edc_2) |
| **Attachment 3** | **Content of activity**: A description of the content with supporting references or resources.[(3.0 Education Planning Table(s))](https://www.ena.org/docs/default-source/education-document-library/3-0educationplanningtable-approver.docx?sfvrsn=34ffcff8_2) |
| **Attachment 4** | **Number of contact hours** awarded for activity, including method of calculation. (Provider must keep a record of the number of contact hours earned by each participant.) If the activity is longer than 3 hours, attach the agenda for the entire activity. If you are seeking designations or have concurrent sessions, please complete the provided 4.0 Contact Hour Matrix. [(4.0 Contact Hour Matrix)](https://www.ena.org/docs/default-source/education-document-library/4-0contacthourmatrix.doc?sfvrsn=d70aabc2_2) |
| **Attachment 5** | **Certificate** or documentation of completion *(if not using ENAs certificate that will be sent with approval documents).* Reminder: (Provider must retain a unique identifier of learners for six (6) years and the number of contact hour awarded to each participant). The certificate must include the name and address of the provider (not the location of the activity), a space for the name of the learner, the date and title of the activity, the number of contact hours awarded, and the activity approval statement. |
| **Attachment 6** | **Disclosure**: Evidence of required information *provided to learners prior* to start of the educational activity:* 1. Approval statement as issued by the accredited provider
	2. Criteria for successful completion in order to receive contact hours
	3. Presence or absence of conflicts of interest (COI) for all individuals in a position to control content (e.g. Nurse Planner, Content Expert, Planning Committee Members, Content Reviewers and Speakers/Faculty/Presenters/Authors)
	4. If COI is present, disclosure must include name of individual, nature of relationship, and name of commercial entity
	5. Commercial support (*if applicable*)

*If this activity will have commercial support—you must disclose to learners** 1. Expiration date (enduring materials only)
	2. Name(s) of Joint Provider(s)(*if applicable*)

*If this activity will have a joint provider—you must disclose to learners* Note: (Materials associated with the activity (marketing materials, advertising, agendas, and certificates of completion) must clearly indicate the Provider awarding contact hours and responsible for adherence to ANCC criteria[(5.0 Disclosure Handout—modify to your activities needs)](https://www.ena.org/docs/default-source/education-document-library/5-0disclosurehandout.docx?sfvrsn=4b92f931_2) |
| **Attachment 7** | **Commercial Support** Agreement with signature and date (*if applicable*)[(6.0 Commercial Support Agreement)](https://www.ena.org/docs/default-source/education-document-library/6-0commercialsupportagreement.docx?sfvrsn=5cdb4e71_2) |
| **Attachment 8** | **Advertising:** If providing advertising materials, please submit a copy. The appropriate accreditation statement must be included.When advertising PRIOR to approval of the CNE application, the following statement must appear on promotional materials:***This activity has been submitted to the Emergency Nurses Association for approval to award contact hours. The Emergency Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.***When marketing a program AFTER approval of the application, the following statement must appear on promotional materials:***This continuing nursing education activity was approved by the Emergency Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.*** |

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| **Nurse Planner Understanding and Attestation** |
| On behalf of insert name of applicant organization, 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 this applicant, that this applicant will comply with all eligibility requirements and approval criteria throughout the entire approval period, and that the applicant will notify ***Emergency Nurse Association*** promptly if, for any reason while this application is pending or during any approval period the 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 ***Emergency Nurse Association*** to deny, suspend or terminate this applicant’s approval of this individual activity.I will retain all documents for this educational activity/program for a minimum of **six (6) years** in a safe and secure manner (*the provider of this activity must keep a record of the number of contact hours earned by each participant and their unique identifier*). *(Application Forms received without a signature incur a delay in processing which will cause a delay in the review of the individual education activity application.)*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 contained.**The nurse planner is held accountable for all information provided in the application.** |
| **Completed by Nurse Planner Name:** | Click here to enter text. |
| **Date Application Completed:** | Click here to enter a date. |

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| **ENA Office Use Only** |
| **Nurse Planner RN Licensure Verified By:** | Click here to enter text. |
| **ENA Staff Signature:** | Click here to enter text. |
| **Date Verified:** | Click here to enter a date. |