



CONTINUING PROFESSIONAL EDUCATION

Application for a CE Activity
Telephone: (813) 974-4296; Fax: (813) 974-3217

CPE Office Use Only: USF Cosponsored Joint Sponsored

Program Code: _____ Division: _____

On Brochure Print Program Code as Follows: _____

APPLICANT

Continuing Education Credit is being requested for (check all that apply and list the number of credits requested):

- Physicians _____
- Nurses* (FBN _____ or ANCC _____)
- Pharmacists _____
- Psychologists _____
- Physical Therapists _____
- Other _____

*A supplemental application will be sent to applicants requesting nursing credit. Nursing credit: 50 minutes = 1 contact hour

Organization and/or Department: School of Physical Therapy & Rehabilitation Sciences, College of Medicine

Program Director: Janice Pitts, PT, PhD Phone: 974-2254

Contact Person: _____ Phone: _____
(If other than Program Director)

Address: 12901 Bruce B Downs MDC 77 USF, College of Medicine,
School of Physical Therapy & Rehabilitation Sciences

City: Tampa State: FL Zip Code: 33612

PROPOSED ACTIVITY

Title: _____

Type of Activity: (Check all that apply)

- One Time Activity: Indicate Date(s) & Time(s): _____
Location: _____
- Repeating Activity: Date(s) of Series: _____
Location(s): _____
- Enduring Material: Start Date _____
End Date: _____
Comments: _____

Projected Attendance: _____ Attendance Limit(s) if any: _____ None _____

List Planning Committee: (faculty of the School of PT)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Target Audience: (This CE activity is planned to meet the needs of what group(s) of practicing healthcare professionals?) _____

What other healthcare professionals are invited to attend this activity? _____

List any prerequisite knowledge/skill for the CE activity _____

Needs Assessment

What procedures were used to identify CE needs? Include data sources which go beyond the planning committee's perception of need. **Documentation must be attached.**

- Survey of potential participants
- Use of clinical practice data
- Quality assurance studies
- Practice profiles
- Opinion of experts in specialty field(s)
- Problem identified internally
- Regularly scheduled review of current subjects
- Specific request by target audience
- Review of previous CPE evaluations
- Presentation of new information: diagnostic techniques, treatment plans, management, etc.
- Mandate by State Licensing Board
- Other: _____

State the overall needs identified by the above processes and indicate how this assessment is used in planning this educational activity. _____

Course Objectives

As a result of participation in this CE program, participants will be able to:

Teaching Faculty

Who are the *potential* teaching faculty for this activity?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

How were they selected?

Content expertise

Activity Promotion

How will prospective participants be notified of the activity?

- Brochure/Flyer E-Mail Health Sciences Center Newsletter
- Posted Announcement Fax Internet
- _____

The CPE Office must review and approve all drafts of brochure(s)/promotional material(s) PRIOR to printing, posting or mailing. Failure to obtain CPE Office approval may result in decertification of the course for credit.

Budget/Finances

What funds will pay for the expenses of the CPE activity? (Check as many as apply.) **Attach preliminary budget with this application.**

- Internal department funds (part of community service of each faculty)
- Participant registration fees of \$ 0.00 (per person)
- Commercial support (*Vendor contract must be initiated by the CPE Office when commercial support is provided*).
- State or Federal Grant
- Other support: _____

Evaluation

Indicate what evaluation method(s) you plan to use:

- Standard CE evaluation form (provided by the CPE Office)
- Other evaluation form (Attach a sample for review and approval by the CPE Office)
- Other: _____

CONTINUING EDUCATION CREDIT HOURS

The proposed agenda, including topics and speakers, must be submitted with the application in order for the CPE Office to calculate the appropriate number of continuing education credit(s).

Indicate the requested number of credit hours or contact hours: _____

I certify that the information contained in this application for CE approval is true and correct to the best of my knowledge.

Program Director Signature: _____ (one person on each team sign electronically using /s/ symbol)

Department/Institution: __, USF

Return application to:

USF CPE Office
MDC Box 46
12901 Bruce B. Downs Blvd.
Tampa, FL 33612

CPE Office Use Only	
Date received _____	By: _____ Mail _____ Fax _____ Hand Delivered
CE Committee Review: _____	
Date	
Committee Action:	
<input type="checkbox"/> Approved for _____ hours of continuing education credit.	
<input type="checkbox"/> Provisional approval, pending	
<input type="checkbox"/> Denied _____ Reason: _____	
Date	
Executive Director, CPE: _____	
Date: _____	