**KANSAS STATE BOARD OF NURSING**

**LANDON STATE OFFICE BUILDING**

**900 SW JACKSON, SUITE 1051**

**TOPEKA, KS 66612-1230**

# Continuing Nursing Education Annual Report

Each approved long-term CNE provider shall pay a fee for the upcoming year and submit an annual report for the period of July 1 through June 30 of the previous year on or before the deadline designated by the board (K.A.R. 60-9-107).

Please review these instructions before completing the annual report:

1. The annual report is due no later than July 31 and covers data from July 1 of the prior year through June 30 of the present year. This report will be submitted electronically and there are attachments you need to submit with this annual report. The documents you attach need to be in Word or PDF format.

2. Each approved long-term CNE provider must pay the annual fee of fifty ($50.00) dollars. An invoice will be emailed to the Coordinator listed for each long-term provider. Mail this fee to KSBN at the address listed on the invoice along with a copy of the invoice.

3. The Total Program Evaluation must be attached to this annual report before this annual report is submitted electronically. The Total Program Evaluation needs to be in Word or PDF format. One example of a total program evaluation is presented below.

4. For EACH of the first two years of the providership you must attach the following required materials for one CNE offering (ex: if initial approval occurred after July 1, 2012 you must submit the following for one CNE offering for EACH year):

a. A summary of the planning

b. A copy of the offering announcement or brochure

c. The title and objectives

d. The offering agenda or, for independent study, pilot test results

e. A bibliography

f. A summary of the participants' evaluations

g. Each instructor's education and experiences

h. Documentation to verify completion of the offering

**Total Program Evaluation example:**
*It may be presented as a narrative or a chart or in any format appropriate for the provider.*

| Area | Frequency | Resp. Person | Criteria | Findings | Actions/Recommendations |
|---|---|---|---|---|---|
| ***Administration*** | | | *Review job description* | | |
| ***Policies:*** | | | *Review survey for appropriateness; were survey findings and identified needs from evaluation summaries used in program planning* | | |
| ***Assess need, planning*** | | | | | |
| ***Written Tool*** | | | | | |
| ***Evaluation Summaries*** | | | | | |
| ***Policies:*** | | | *Policy meets organization and customer needs* | | |
| ***Fee Assessment*** | | | | | |
| ***Policies:*** | | | *Review to be certain they reflect necessary information* | | |
| ***Announcement*** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ***Policies:*** | | | *Review policies and compare to KSBN requirements* | | |
| ***Offering Approval Process*** | | | | | |
| ***Policies:*** | | | *Review agendas/pilot test results to verify contact hours awarded; review documentation of partial credit* | | |
| ***Awarding Contact Hours*** | | | | | |
| ***Policies:*** | | | *Review rosters and certificates; compare to KSBN requirements* | | |
| ***Verifying Participation/Completion*** | | | | | |
| ***Policies:*** | | | *Audit contents of files for compliance with KSBN requirements* | | |
| ***Record Keeping*** | | | | | |
| ***Policies:*** | | | *Review procedures for changes reported to KSBN* | | |
| ***Notification of Changes*** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ***Total Program Evaluation Effectiveness*** | | | *Review total program evaluation and compare contents to KSBN requirements* | | |

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**Continuing Education Annual Report**

Name of Provider: _____

Provider Number (for Renewal): _____

Legal Body (if different from provider): _____

Address of Provider: _____

Telephone: _____

E-Mail Address: _____

Program Coordinator: _____

Reporting Year: _____

# Interactive Offerings

Total Number of Offerings: _____

Total Number of offering Contact Hours: Sum of all contact hours presented _____

Total Number of APRN Participants: _____

Total Number of RN Participants: _____

Total Number of LPN Participants: _____

Total Number of LMHT Participants: _____

*Offering Contact Hours taught by: Sum of OH taught by each category total should be the same as :Total Number of Offering Contact Hours*

Nurses: _____

Others: _____

# Independent Study Offerings

*Complete only if you offer Independent Study*

Number of Independent Study topics offered: _____

Total Number of Independent Study Contact Hours: _____
*Sum of all contact hours for IS topics*

Total Number of APRN Participants: _____

Total Number of RN Participants: _____

Total Number of LPN Participants: _____

Total Number of LMHT Participants: _____

*Attestation*
*I realize that this application is a legal document and by submitting this application you are declaring under penalty of perjury under the laws of the State of Kansas that the information I have provided is true and correct to the best of my knowledge.*
*If all the above information is correct please sign and date below.*
*Otherwise please go back and correct any information that is necessary.*

Signature: _____ Date: _____