

APPROVED THROUGH

KENTUCKY BOARD OF NURSING
312 WHITTINGTON PARKWAY, SUITE 300
LOUISVILLE, KY 40222-5172
(502) 429-3300

FOR KBN USE ONLY

Date Paid _____

Amount Paid _____

Reviewed By

Date

APPLICATION FOR PROVIDER RENEWAL

INSTRUCTIONS: Please type or print the information requested and submit to the Kentucky Board of Nursing at the above address by September 30th.

The application fee must be submitted with the completed application form.

1. PROVIDER CORE NUMBER: _____
2. PROVIDER NAME: _____
ADDRESS: _____

PHONE NO: _____ FAX NO. _____
E-MAIL ADDRESS: _____
3. NURSE ADMINISTRATOR:
NAME: _____
LICENSE NO: _____ PHONE NO. _____
4. CHIEF ADMINISTRATIVE OFFICER OF PROVIDER ORGANIZATION/AGENCY:
NAME: _____
TITLE: _____
5. DO YOU WISH CONTINUED PROVIDER APPROVAL? YES _____ NO _____
6. **Complete and submit** one copy of the attached "Official Record of Providership Continuing Education Activity."
7. **Complete and submit** one copy of the attached "Retrospective Self-evaluation."

In accordance with the intent of Kentucky Revised Statute 314.073 and Kentucky Administrative Regulations 201 KAR 20:200, 20:215, and 20:220, I hereby agree to comply with the specified requirements regarding the provision of mandatory continuing education activities.

Signature of Nurse Administrator

Date

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PROVIDER NAME: _____ CORE NO. _____

Please include the following information to help KBN keep our web page information up to date on all providers. If the requested information is not submitted, your providership name will not be included on the specific course content lists that appear on the KBN web page and is mailed to nurses and agencies upon request.

DOES YOUR CE PROVIDERSHIP OFFER THE FOLLOWING COURSES TO THE GENERAL PUBLIC?
(Please circle all that are offered by your providership)

| | | |
|--|-----|----|
| DOMESTIC VIOLENCE | YES | NO |
| I.V. THERAPY | YES | NO |
| HIV/AIDS | YES | NO |
| PHARMACOLOGY | YES | NO |
| SEXUAL ASSAULT or FORENSIC MEDICINE | YES | NO |

DOES YOUR CE PROVIDERSHIP OFFER COURSES ON THE **INTERNET**? YES NO

IF YES, PLEASE INCLUDE THE **WEB ADDRESS** WHERE THE CE COURSES ARE OFFERED.

CONTINUING EDUCATION PROVIDER SELF-EVALUATION

PROVIDER NAME: _____ **CORE NO.** _____

Reporting Period:

I. STATISTICS

Using data from the Official Record of Continuing Education Providership Activity, indicate below the approximate number of offerings and the number of nurses attending for this reporting period.

Number of Offerings _____ Nurse Participants RN _____ LPN _____

II. PARTICIPANT EVALUATION SUMMARIES:

Were any items on the Participant Evaluation Summaries from this reporting period rated below average by more than 20 percent of the participants?

YES _____ NO _____

If you answered yes to the above question, please append, in chronological sequences, those Participant Evaluation Summaries. An explanation for and a resolution to correct the below average rating must be included.

III. OFFERING ANNOUNCEMENTS:

Please **attach** a copy of an offering announcement for an offering presented during this reporting period.

IV. SCHEDULE OF OFFERINGS:

Enclose one (1) copy of the proposed schedule of offerings to be presented during the next reporting period. Proposed schedule should include offerings by title and anticipated presentation date.

The Board reserves the right to request submission of copies of continuing education files from the provider.

V. SUBJECTIVE DATE

List the three (3) major strengths of the providership continuing education activities during the reporting period.

List the three (3) major weaknesses of the providership continuing education activities during the reporting period.

Based upon an analysis of the strengths and weaknesses identified, what strategies for resolution of providership challenges and problems are planned? Designate target dates.

| CHALLENGES/PROBLEMS | STRATEGIES FOR RESOLUTION | TARGET DATE |
|----------------------------|----------------------------------|--------------------|
|----------------------------|----------------------------------|--------------------|

