**Connecticut Nurses’ Association**

**APPROVED PROVIDER UNIT**

***2020 Annual Monitoring Report***

Please **EMAIL** this form, requested documents from one (1) completed activity, and a full listing of your 2019 activities to education@ctnurses.org

Payment arrangements should be made by clicking this link

[Annual Reports Fee](http://ow.ly/FpSW30mFRGJ)

The Annual Report Fee is $125

**Approved Provider Name:** Click here to enter name.

**Today’s Date:**  Click here to enter a date.

**Primary Nurse Planner (PNP) Name**: Click here to enter Primary Nurse Leader Name

**PNP License number and State:** Click here to enter license number and state

**PNP Email:** Click here to enter email

**Contact Person Name:** Click here to enter Contact Person Name

**Contact Person Email:** Click here to enter email

***USE THIS FORM TO RESPOND – PLEASE INCLUDE ONLY THE MATERIALS REQUESTED***

**Resources**

1. **Have there been changes in the Administrator or Nurse Planner(s) in your Provider Unit?**

Choose Yes/No

 If yes, explain. Click here to explain

 In addition, supply Biographical Data / Conflict of Interest form for the new personnel.

1. **Complete the Provider Unit Self-Assessment Summary form** (see below)
2. **Have you approved any external activities during the past year?**

Choose Yes/No If yes explain. Click here to explain

**Approval of these activities lies with the CNA accredited approver unit.**

1. **Submit the following:**

 [ ]  The complete educational file for **ONE (1)**Educational Activity to include:

* + Approved Provider Planning Paperwork
	+ Approved Provider Conflict of Interest form for all planners, content experts, and speakers/facilitators
	+ Approved Provider Attendee Activity Certificate
1. Are you maintaining all files for 6 years? Choose Yes/No

If no explain Click here to explain

1. Describe one quality improvement activity relative to the operations of your approved provider unit that was implemented this past year. Discuss the source of the quality improvement idea, the action taken, and the outcome.

Click here to explain

**Educational Activities Presented**

Please complete the [**Continuing Education Activity Summary**](https://ctnurses.org/Approved-Provider)Worksheet and send with this form and your sample activity.

List all activities for the **past year (January 2019 – December 2019)** for which you awarded nursing contact hours.

***Please include totals on this worksheet.***

Place an **R** beside the title of an activity offered repeatedly during the reporting period.

**PROVIDER UNIT SELF-ASSESSMENT SUMMARY**

*(Attach additional lines as necessary)*

**Provider Unit Strengths**

1. Click here to enter text.

2. Click here to enter text.

**Areas for Improvement/Enhancement of the Provider Unit**

1. Click here to enter text.

2. Click here to enter text.

**Plan for Implementing the Improvement/Enhancement**

1. Click here to enter text.

2. Click here to enter text.

**By placing an “X” in each box below, the Lead Nurse Planner acknowledges adherence to the following:**

[ ]  Reviews, understands, and is in compliance with current ANCC/CNA guidelines and criteria;

[ ]  Does not approve activities internally or externally;

[ ]  Maintains compliance with all applicable federal, state and local laws and regulations; and

[ ]  Understands that providing false, misleading, or incomplete information is grounds for revocation of approved provider status

**Typed or Electronic Signature Primary Nurse Planner: Name and Credentials (Required)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date.