**Continuing Nursing Education Activity Summary Report**

**Educational Activity Title:** Click here to enter text. **Contact Hours Awarded:** Click here to enter text.

**Primary Nurse Planner:** Click here to enter text.

**Coordinator:** Click here to enter text. **Co-Provider (if applicable):** Click here to enter text.

**Date(s)** Click here to enter a date.

**Activity Attendance:** **(attach attendance sheet) Total # attended:** Click here to enter text.

|  |  |
| --- | --- |
| **Category** | **# attended** |
| **RN- Required** | Click here to enter text. |
| **LPN- optional** | Click here to enter text. |
| **CNA- optional** | Click here to enter text. |
| **MD- optional** | Click here to enter text. |
| **Pharmacist- optional** | Click here to enter text. |
| **Social Worker-optional** | Click here to enter text. |
| **Dietician-optional** | Click here to enter text. |
| **Other- optional** | Click here to enter text. |

**Summary:**

Educational Activity Needs Assessment: Click here to enter text.

Educational Activity Objective(s): Click here to enter text.

Participant Evaluations: Click here to enter text.

Overall Evaluation/Comments: Click here to enter text.

Problems/Opportunity for Improvement: Click here to enter text.  
If applicable: Click here to enter text.

Indicate if the appropriate verbal disclosure occurred at this activity. Choose an item.