**Connecticut Nurses’ Association**

**APPROVED PROVIDER UNIT**

***2022 Annual Monitoring Report***

Please **EMAIL** this form, requested documents from one (1) completed activity, and a full listing of your 2022 activities to education@ctnurses.org

Payment arrangements should be made by clicking this link

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

The Single Organization Annual Report Fee is $200

The Network Organization Annual Report Fee is $250

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

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

**Primary Nurse Planner (PNP) Name and Credentials**: 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. **Provide a list of your Nurse Planner(s) with credentials in your Provider Unit**

 Supply Biographical Data / Conflict of Interest form for new personnel.

1. **Complete the Provider Unit Self-Assessment Summary form** (see below)
2. **Submit a complete educational file for ONE (1)Educational Activity**

**Educational Activities Presented**

All activities for the **past year (January 2022 – December 2022)** for which you awarded nursing contact hours must be submitted in NARS

**PROVIDER UNIT SELF-ASSESSMENT SUMMARY**

*(Attach additional lines as necessary)*

**Provider Unit Strengths**

Click here to enter text.

**Identify one quality outcome the provider unit has established and worked to achieve over the past twelve months to improve provider unit operations. Identify how the outcome was developed, measured, and analyzed. Include the metrics used to measure success in achieving that outcome.**

Click here to enter text.

**By placing an “X” in each box below, the Primary 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 for any other individuals or organizations

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

[ ]  Maintains all files for 6 years

[ ]  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)**

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Name and Credentials Date: