



**APPLICATION FOR APPROVAL OF CONTINUING
EDUCATION PROGRAMS FOR RESPIRATORY CARE
PRACTITIONERS**

State Form 50323 (R3 / 7-22)

**RESPIRATORY CARE COMMITTEE
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-8800
E-mail: pla14@pla.in.gov

INSTRUCTIONS: Please type and answer all questions.

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY

Date received / postmarked (<i>month, day, year</i>)	Date of approval (<i>month, day, year</i>)	Continuing education hours granted
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DO NOT WRITE ABOVE THIS LINE

SPONSORING ORGANIZATION

Name of Sponsoring Organization		
Address (<i>number and street or post office box</i>)		
City	State	ZIP code
Telephone number (<i>daytime</i>) ()	E-mail address	

PROGRAM COORDINATOR

Name(s) of Course Coordinator(s)	Title	
Mailing address (<i>number and street or post office box</i>)		
City	State	ZIP code
Telephone number (<i>daytime</i>) ()	E-mail address	

PROGRAM TO BE OFFERED

Program title	<input type="checkbox"/> Single offering <input type="checkbox"/> Multiple offerings
Program date(s)	
Location of program (<i>city and state</i>)	
Number of Continuing Education hours requested	

TYPE OF PROGRAM

Conference / Seminar Special Training Program Videotape

OBJECTIVES

List the objectives for the continuing education course.

Empty space for listing objectives.

ADMINISTRATION

Who planned the overall program?

Empty space for answer.

Who will maintain adequate records of course participants and certify to their accuracy?

Empty space for answer.

What is the anticipated enrollment?

Empty space for answer.

CURRICULUM

List the curriculum by subject areas, the continuing education hours planned, the faculty members, the proposed method of presentation and presenter's resume for each subject area.

SUBJECT	HOURS	FACULTY	PRESENTER	METHOD OF PRESENTATION

FACILITIES

At what type of facility will the course be conducted?

Empty space for answer.

List any clinics, hospitals, or other organizations involved in the training program, if applicable.

Empty space for answer.

EDUCATIONAL METODOLOGY

Check the educational methods being employed in the course.

- Laboratory Experience
- Lectures
- Question-Answer Period
- Group Discussion

What teaching aids will be used? (Check applicable spaces.)

- Videos
- Slides / PowerPoints
- Flip Charts / Whiteboards
- Other:

If the group is to be divided for some of the course, list the approximate size and the type of method to be employed

Empty space for answer.

EVALUATION

What type of evaluation will be conducted to measure the program's content and effectiveness? *(Please submit copy of proposed evaluation.)*

Will an evaluation be made by the individual participant? How so?

How will the evaluation be used to improve future course offerings?

Does the "Certificate of Attendance" that will be awarded to the respiratory care practitioner state the following:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Sponsor of the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Name of the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Date of the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Number of continuing education hours awarded? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

NOTE: Each participant must be provided a certificate of attendance.

ADDITIONAL INFORMATION REQUIRED

1. Have you enclosed the following items:

- | | | |
|---|------------------------------|-----------------------------|
| a. One (1) original and one (1) copy of the program brochure or a draft copy of the information to be provided in the brochure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. One (1) original and one (1) copy of the evaluation form? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. One (1) original and one (1) copy of your application for continuing education approval? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

2. Have specific time intervals been specified for each activity in the brochure?

Yes No

3. Has the content of the program been documented and included with the application?

Yes No

4. If the program is a multiple day program have you indicated on which day each topic will be presented?

Yes No

5. Have all faculty member / speakers presenting the program been identified by name and title?

Yes No

6. Is this program a videotape? If yes, please provide specific dates the videotape will be shown and the date the video tape was originally produced.

Yes No