**APPLICATION FORM FOR APPROVAL OF CONTINIOUS PROFESSIONAL DEVELOPMENT (CPD) PROVIDERS STATUS**

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| **Jigjiga university** | **College of Medicine and Health Science** |
| **APPLICATION FOR APPROVAL FORM OF CONTINUING PROFESSIONAL**  **DEVELOPMENT (CPD) PROVIDERS** | |
| **Please complete and submit this application to a Profession-specific Accreditor**  **NOTE:** The Program for the Activity and the Presenter’s CV must be submitted with this application preceding the activity. No retrospective approval will be made. | |
| 1. Name of applying organization | |
| 2. Organization category | a. Public  b. Private |
| 3. Type of organization | a. Professional Association  b. University  c. Health science college  d. Consultancy firm with the experience of giving training  e. Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Address of the Organization/Provider | Region\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_  Sub-city\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Kebele House No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  P.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No\_\_\_\_\_\_\_\_\_\_\_  E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5. Do you have/arrange an office? | a. Yes  b. No |
| 6. Internet Website | a, Yes  b. No |
|  If yes, please specify website address | |
|  Will you be posting lists of accredited activities on the website? | a. Yes  b. No |

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| 7. Do you have/potential to hire administration assistant/secretary? | a. Yes  b. No |
| 8. Do you have designated CPD director/coordinator? (Attach academic document, professional license and CV) | Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_  e-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9. Have you applied to another accreditor to have this activ  ity approved? If yes, to whom and what was the outcome? Provide a reason if the application was not approved. | Name of Accreditor: No.  Outcome and reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **The following information must be submitted in support of your application** | |
| * A broad outline of the program for the forthcoming year | |
| * State the facilities available for the presentation of CPD activities (lecture rooms, etc) | |
| * State the method for recording attendance | |
| * State the fees to be levied for CPD activities in Level 1 or 2 | |
| * Attach a copy of the proposed attendance register | |
| * Attach a copy of the attendance certificate that will be provided on completion of the activity | |
| * State the method to be used for obtaining feedback or evaluation of the event | |
| * Specify the intended mechanism for monitoring attendance (per hour or session) for the duration of the activity | |
| * State your or your institution/ organization’s involvement or experience in healthcare education | |
| * State your proposed target audience, | |
| Has an application already been submitted to another Accreditor requesting approval? | |
| **In order to be awarded accredited service provider status, you agree to:**  Exercise integrity and ethical behavior in the allocation of CEUs for learning activities;  Record the name, professional registration number and the CEUs awarded to every participant at each CPD activity;   Validate participant attendance for the entire event;   Provide participants with attendance certificate /evidence of completion;   Submit an annual report on activities presented;   Safeguard the records for at least three years,   Be subjected to quality assurance checks as may be deemed necessary by the Ministry from time to time. | |
| Name of the applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of the applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of application \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |