

Provider Organization: _____

Title of Activity: _____

Date(s), if live: _____

Individual's role(s) in this Educational Activity: *(check ALL that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Presenter/Author | <input type="checkbox"/> Planning Committee Member |
| <input type="checkbox"/> Content Expert (Subject Matter Expert) | <input type="checkbox"/> CNE Nurse Planner responsible for this activity |
| <input type="checkbox"/> Content Reviewer | <input type="checkbox"/> Primary Nurse Planner <i>(Approved Providers only)</i> |
| <input type="checkbox"/> Other faculty in control of content (describe): _____ | |

Name and Credentials: _____

For RNs, "X" nursing degrees held: ADN Diploma BSN MSN Doctorate

Organization/Employer: _____

Current Position/Title: _____

Mailing Address: _____

Phone: _____

Email: _____

Your educational preparation: *(include basic through highest degree held)*

Degree	Major Area of Study	Institution – Name, City, State

1. ALL PRESENTERS/AUTHORS/CONTENT REVIEWERS/FACULTY/PLANNERS/NURSE PLANNERS:

Describe your relevant professional experience, continuing education, or other information that qualifies you for your role as a presenter, developer, reviewer, or planner of educational content:

2. ALL PRESENTERS/AUTHORS/CONTENT REVIEWERS/FACULTY/ PLANNERS/NURSE PLANNERS with subject matter expertise:

Describe your relevant professional experience, continuing education, or other information that qualifies you as a subject matter expert:

3. Complete this section if you are a NURSE PLANNER for the ORGANIZATION RESPONSIBLE FOR AN EDUCATIONAL ACTIVITY OR if you are a PRIMARY NURSE PLANNER of a WNA CEAP APPROVED PROVIDER UNIT:

- A *Describe how you were oriented to, or have current knowledge of, the 2015 ANCC/WNA CEAP criteria for planning, implementing and evaluating continuing nursing education (CNE) activities:*
- B *Describe your experience related to the functions of your role either as a Nurse Planner for this activity or Primary Nurse Planner of a WNA CEAP Approved Provider Unit:*

PRIMARY NURSE PLANNERS of APPROVED PROVIDER UNITS only:

- C *Licensure as a Registered Nurse: (must be current)*

RN License Number: _____ State: _____ Expiration (month/year): _____