MARYLAND BOARD OF PHARMACY
4201 PATTERSON AVE, BALTIMORE, MD 21215-2299
(410) 764-4755 (800) 542-4964 MD Only (410) 358-6207 Fax

CONTINUING EDUCATION PROGRAM APPROVAL FORM

BOARD USE ONLY

PROGRAM NUMBER**:** _____

DATE APPROVED: _____

EXPIRATION DATE: _____

APPROVED CE CREDIT: ____ HOURS**:** ____

APPROVED BY: _____

DESCRIPTION: The program provider is directed to follow the guideline in completing this form. Incomplete forms may be returned for further information delaying program review and reply. You should submit this request at least 45 days before the date an answer is needed.

1. Names and address of organization or individual seeking approval:

_____ _____
Name (Print or type) *Date*

_____
Address

_____ _____ _____
City *State* *Zip*

_____
Telephone Number)

2. Name and address of individual responsible for continuing education program where this differs from #1:

_____

Name (Print or type)

_____

Address

_____ _____ _____

City *State* *Zip*

As a program provider do you agree to:	YES	NO
(a) maintain attendance records for this program?	☐	☐
(b) include name and address of participants on attendance records?	☐	☐
(c) maintain attendance records so that completion or hours completed will be shown?	☐	☐
(d) provide a certificate to each participant of satisfactory completion of the program which includes:	☐	☐

(1) Name of the participant:
(2) Name of the provider:
(3) Description of course work:
(4) Number of hours:
(5) Date of completion of program
(6) An authorized signature and Program Identification Number (Board Approved Number) should be noted on the Certificate of Attendance

(e) make such attendance records available on request to participants or board for six years after completion of program?	☐	☐

3. Do you agree to:

	YES	NO
(a) maintain description of content of this program?	☐	☐
(b) make program description available to participant or board for six years after completion of last program presentation?	☐	☐
(c) submit a copy of a summary of the evaluation results if requested to do so?	☐	☐

4. PROGRAM TITLE: _____

5. DESCRIPTION OF PROGRAM:

(a) Program Site: _____

(b) Program date(s): _____

(c) Number & length of program units: _____

(d) Type: (seminar, correspondence, etc.) _____

(e) Duration of total program: _____
(for seminar, study group, etc.) _____ contact hours
(for self-study programs) _____ estimate study time.

(f) Nature of audience for whom program is prepared: _____

(g) Number of attendees anticipated: _____

6. Program Goals:

_____

_____

7. Program Learning Objectives:

_____

_____

8. How will the program be presented? (e.g., lecture, panel, discussion group, workshop, group study session, private study, etc.)

_____

_____

9. What types of audio/visual aids will be used? (Please check those which are applicable.)

☐ Slides ☐ Films ☐ Video tapes

☐ Exhibits ☐ Audio cassette tapes ☐ Charts

☐ Other (describe): _____

	YES	NO
10. Will program outlines be made available to participants?	☐	☐
11. Will case histories be used in the program?	☐	☐
12. Will an annotated reading list be made available?	☐	☐

13. PROGRAM FACULTY & QUALIFICATIONS (attach additional information, if appropriate):

Name:_____ Position: _____

Name:_____ Position: _____

14. Describe the methods to be used in evaluation of this program in terms of procedures, processes, and results (Attach copy of evaluation form to be used):

15. OTHER INFORMATION WHICH YOU MAY WISH TO RELATE:

16. Please enclose promotional brochures, program schedule, materials, outlines, etc.

PERSON COMPLETING THIS FORM:

Name (Print or type)

Address

City *State* *Zip*

Telephone Number (HOME) *(WORK)*

Signature *Date*

Please return this completed form to:

Maryland Board of Pharmacy
P.O. Box 2051
Baltimore, MD 21203-2051

Web site: http://dhmh.maryland.gov/pharmacy/

CLEAR FORM PRINT FORM