Steven W. Schierholt, Esq.
Executive Director

John R. Kasich
Governor

STATE OF OHIO BOARD OF PHARMACY

CONTINUING PHARMACY EDUCATION PROVIDER APPROVAL PROGRAM

Introduction

The primary goal of the approval mechanism is to assure that Ohio pharmacists are provided with quality continuing pharmacy education consistent with the intent of the Legislature when the continuing education provisions were added to the Pharmacy Practice Act. The achievement of quality in this area will take time to develop. The Board approval mechanism is intended to be a means of assistance to the provider in achieving this goal. In this application of the Criteria for In-State Providers, the Board does not expect literal conformity in every detail. In fact, certain questions probably bring up points which some providers never even considered in the past when planning continuing pharmacy education experiences.

Providers should keep in mind that although the Board will be evaluating past performance, the primary purpose of the questionnaire is to seek assurance that the Provider is willing and able to meet the Criteria for In-State Providers. Providers should not look on this questionnaire as an attempt by the Board to harass or intimidate them. The requested information is needed so that the Board will have a sufficient amount of data available to determine if a Provider should be approved. The questions also serve to assist the Provider in assessing its own strengths and weaknesses and areas in need of improvement.

This questionnaire has been developed with an appreciation of the wide variety of providers that exist. For this reason, there may be items in the questionnaire that may require a degree of interpretation to render them applicable to certain types of Providers. The Board stands ready to assist the provider in the preparation of this questionnaire.

Instructions

- The reference period for all items relating to programs offered in the past 12 months.
- Please complete all responses and maintain a copy of the questionnaire submitted in your files.
- The amount of space for responses on the questionnaire is not intended to dictate the length of the responses. Please use additional pages for responses requiring additional space. Please identify the question to which such responses refer.
- Please return the attached questionnaire, supplemental forms, and any additional forms used to the Board office via email to CEProvider@pharmacy.ohio.gov. Direct any questions you have to the Board's Continuing Pharmacy Education Coordinator by calling 614/466-4143 or email at CEProvider@pharmacy.ohio.gov.

Per OAC 4729-7-05 (C), approval of in-state providers shall be valid for a period of three years at which time reapplication is necessary. It is your responsibility to apply for renewal before the current approval expires.

-- QUESTIONNAIRE --

Official name of organization, individual, institution, association, corporation, or agency that is applying for approval as a provider of continuing pharmacy education:

Name or organization/institution :

_____

Street Address:

_____

City & State:_____Zip Code:
_____

Email address of CE Coordinator:_____ .

Area Code/Phone No.: _____

I. Administration

A. Administrative Authority

1. Name and title of person responsible for the continuing pharmacy education programs:

   Name:_____Title:
   _____

2. Person named in 1. above, please complete "Form A" (attached).

3. If this individual has served in this capacity for less than one year, please indicate predecessor and length of service:

   Name:_____Length of Service:
   _____

   (From - To Dates)

4. If the person in charge is elected or appointed, as with local professional associations, will this person change from year to year?

   Yes☐ No☐ *(Please check one)*

   If yes, it is the responsibility of the organization to notify the Board as soon as a new person is elected or appointed. This must be done by having the individual complete

a new "Form A" and immediately forwarding it to the State of Ohio Board of Pharmacy office.

B. What group or organization have you worked with in the past year in providing continuing pharmacy education?

C. Administrative Requirements

1. Describe the means by which programming is or will be promoted:

2. What system will be used for the maintenance and availability of records of participation in continuing pharmacy education activities and where will they be stored?

3. Attach a sample certificate, letter, or other document that will be used as evidence to participants of satisfactory completion of a continuing pharmacy education activity. Indicate the manner in which this document is distributed to participants. Enclosed sample ("Form B") may be used as a guide.

II. Educational Content Development

A. Describe the goals of your continuing pharmacy education effort.

B. State the goals and educational objectives of your most recently offered activity, or upcoming activity.

C. Describe the steps taken in the planning process for a continuing pharmacy education experience.

D. Describe the manner in which topics for continuing pharmacy education experiences are determined. Indicate how continuing education participants are involved in planning future programs.

E. Describe the review process that an on-going program might undergo before it is offered to a new audience.

III. Methods of Delivery

A. Indicate the number of continuing pharmacy education experiences delivered or sponsored in the past 12 months by each of the methods listed below:

_____ Live Lecture
_____ Workshop/Discussion Group
_____ Film/Videotape
_____ Other (explain)
_____

_____Journal Article with evaluation techniques
_____Home Study Book or Booklet
_____Cassette Tape

B. Please complete "Form C" (attached) for programs offered in the past 12 months.

IV. Evaluation

A. What opportunities will be given for the participants to assess his/her achievement of personal objectives? Please attach a sample of a typical evaluation instrument.

B. How will you evaluate the effectiveness of the continuing pharmacy education experiences and the level of fulfillment of the stated objectives?

V. Additional Information, if any

Indicate any information which will help evaluate your ability as a provider to comply with the criteria for In-State Providers as set forth in O.A.C. Rule 4729-7-06 (copy attached).

Signature and typed or printed name of the person in charge of continuing pharmacy education effort [individual listed in I.(A)(1) on Page Q1]:

_____ _____

(Signature) *(Date of Signature)*

_____

(Name - Typed or Printed)

"FORM A"

CONTINUING PHARMACY EDUCATION ADMINISTRATIVE PERSONNEL

PROVIDER (name of organization/institution)

NAME:	DATE OF APPLICATION:

PERSON IN CHARGE (CE Coordinator)

NAME AND TITLE:	DATE OF BIRTH:
STREET ADDRESS:	DATE APPOINTED:
CITY, STATE, ZIP CODE:	PROVIDER NUMBER: (for re-evaluation only)
E-MAIL ADDRESS:	OHIO PHARMACIST LICENSE NUMBER

EMPLOYMENT (List most recent first)

EMPLOYER:	FROM: (Month/Year)	TO: (Month/Year)
DESCRIPTION:	TITLE:	
EMPLOYER:	FROM: (Month/Year)	TO: (Month/Year)
DESCRIPTION:	TITLE:	

EDUCATION

COLLEGE NAME-Undergraduate:	FROM-TO:	DEGREE:	MAJOR:
COLLEGE NAME-Graduate:	FROM-TO:	DEGREE:	MAJOR:
COLLEGE NAME-Graduate:	FROM-TO:	DEGREE:	MAJOR:

COLLEGE NAME-Honorary Degree:	DEGREE:	DATE:

LICENSED AS A PHARMACIST

DATE:	LICENSE NO.:	STATE:	DATE:	LICENSE NO.:	STATE:
DATE:	LICENSE NO.:	STATE:	DATE:	LICENSE NO.:	STATE:

PROFESSIONAL SOCIETY MEMBERSHIPS

OTHER ACCOMPLISHMENTS (Publications, awards, etc.)

QUALIFICATIONS FOR APPOINTMENT (Experience qualifying person for C.P.E. Responsibility)

"FORM B"

CONTINUING PHARMACY EDUCATION PARTICIPATION

PROVIDER (organization/institution)

NAME:	AREA CODE/PHONE NUMBER:
ADDRESS:	

PROGRAM

TITLE:	DATE:
PROGRAM IDENTIFICATION NUMBER: (Universal 11-digit Program Number)	NUMBER OF C.E.U.S ASSIGNED:

PARTICIPANT

NAME:	R.PH. LICENSE NUMBER & STATE:
ADDRESS:	

CERTIFICATION

SIGNATURE OF PROVIDER'S REPRESENTATIVE:	TITLE

"FORM C"

LIST OF PROGRAMS OFFERED IN THE PAST 12 MONTHS

PROVIDER NAME: _____

Title of Program	Date Offered	Number of Participants	Contact Time	Amount of C.E. Credit	Name(s) of author, speaker, or others presenting program	Method of Delivery*

*****Lecture, cassette, tape, video tape, workshop, home-study, journal article, etc. (PLEASE DUPLICATE THIS FORM AS NEEDED)