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

|  |  |
| --- | --- |
|  **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  |

|  |  |
| --- | --- |
| 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 activity 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |