

## CONTINUING EDUCATION PROVIDER RENEWAL FORM

**Directions:** Please fill out this form for obtaining renewal of your approved provider status in Minnesota. Your completed form should be submitted to the Board of Pharmacy office in advance of the first scheduled date for your continuing pharmaceutical education activity.

**1. Name and address of organization or individual seeking approval:**

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**Phone Number:** \_\_\_\_\_

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

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**3. Administrative requirements:**

- a. Do you agree to maintain attendance records showing the name and address of each participant and the number of hours of their attendance for a period of at least three years?      *(circle one)*      **Yes**      **No**
  
- b. Do you agree to maintain a description of each program you produce and make such description available to the Board for at least three years after completion of the program?      *(circle one)*      **Yes**      **No**

**4. Educational content development:** Do you agree to conduct a needs assessment that involves your anticipated audience, prepare learning objectives and prepare an evaluation instrument?      *(circle one)*      **Yes**      **No**

**5. Methods of delivery:** If home study courses are offered, which do not require personal attendance (e.g. cassette tapes, journal articles, telephonic transmissions, etc.), do you agree to make provisions for the pharmacist to demonstrate completion of these courses?  
*(circle one)*      **Yes**      **No**

6. **Evaluation:**

- a. Describe the methods you anticipate will be employed for the participants to assess their achievement of the objectives stated in the program brochures or announcements:

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- b. Describe the methods you anticipate will be employed to provide feedback to the provider on the program and its presentation:

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7. **Administrative Changes:** Do you agree to keep the Board informed of any administrative changes affecting CE programming? (circle one) **Yes No**

8. **Program Description:** Do you agree to submit a completed Program Description Form in advance of the initial offering of each program? (circle one) **Yes No**

\_\_\_\_\_  
Name and title of person completing this form

\_\_\_\_\_  
Date

**Please return this completed form to:** Cody Wiberg, Executive Director  
Minnesota Board of Pharmacy  
2829 University Avenue SE, Suite 530  
Minneapolis, MN 55414-3251

**Phone Number:** (651) 201-2825  
**Fax Number:** (651)201-2837