CPD Provider Application form

1. The Institute/Provider

- Name of the institute
- Name of the head of the institution/a responsible person for CPD
- Address: ……………………………………..………………………………
- Telephone/Mobile No: ……………………………………………………
- E-mail: ……………………….……………………………………………
- Website address: ………………………………………………………..

2. Brief description of the institute/provider

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3. Details of previous assessment of the institution/provider by the statutory body for CPD programs

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……………………………………………………………………………………

4. Title of the course of CPD offered

……………………………………………………………………………………

5. Details of the keys Trainer/ Facilitator/ Speaker (Please attach updated curriculum vitae and copy of education and qualifications certificates)

- Name:
  …………………………………………………………………………………...
- Education:
  ………………………………………………………………………………
- Qualifications:
  …………………………………………………………………………..
- Name:
  …………………………………………………………………………………...
- Education:
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- Qualifications:
  …………………………………………………………………………..
- Name:
  …………………………………………………………………………………...
- Education:
  ………………………………………………………………………………
- Qualifications:
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6. Course design

- Learning objectives:
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- Total duration:

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- Content and teaching learning approach:
- ………………………………………………………………………………….…..
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7. Logistics relevance to the course offered

a) Human resources (Faculty): (Full-time, Part-time, guest teachers/ lecuture/ resource person and IT personnel participating in the course)

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……….………………………………………………………………………………

b) Learning resources (List of resources and amount)

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…….……………………………………………………………………………
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c) Infrastructure (Number and size of classroom, clinical teaching facilities)

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d) Financial Support (Source of funding & amount):

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……….……………………………………………………………………………
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8. Sélection criteria

a) For faculty/ trainer

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………………………………………………………………………………………
………………………………………………………………………………………

For participants

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………………………………………………………………………………………
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9. Performance evaluation of the participants (Proposed methods used for evaluation)

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10. Suggested credit points for the course(s):

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Case Study Format

Patient's Brief History (Biodata) and Chief Complaints

Present Medical/ Surgical/ Obstetric History

Past Medical/ Surgical/ Obstetric History

Family History

Diagnosis

Investigations (if any)

Name of the Test	Normal Value	Patient Value	Impression

Medication

Name of Drug	Dose	Route	Frequency	Time

Patient's Condition (Assumption/ Observation)

Nursing Care Plan

Nursing Intervention

Evaluation/ Conclusion

References

Signature

Designation

Duty Station

Date

Sample Narrative Note Format

Patient's ID ------------------------- Address/Place.------------------
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Age & Sex ------------------------- Patient serial no -------------
----
Chief complaints-----------------------

Date/ Time	Narrative Notes (SOAPIE)
	S- Subjective Data (Anything related to what the patient has told you) -- -- **O-** Objective Data (measurable information, nurse's observation) -- -- -- -- **A**- Assumption (nurse's interpretation of information on patient's condition) -- -- -- **P**- Plan (care plan, treatment plan) -- -- -- **I-** Intervention (nursing actions taken to support the patient) -- -- -- **E-** Evaluation (results of intervention) -- -- Signature Designation Duty Station Date

Narrative Note Example

- Subjective Data: Patient stated 'I feel headache'
- Objective Data: Vital signs- temperature 102 F, Pulse rate 100 / minute, Respiratory rate 28/minute
- Assumption: The patient appears high fever and discomfort.
- Plan: To maintain normal body temperature, relief from discomfort
- Intervention: Tepid Sponging, increase fluid intake up to 3000 ml, administer drugs prescribed by medical doctor
- Evaluation: One hour after medication and sponging, recheck vital signs.
  Temperature 100 F, Pulse 90/ minute, Respiratory rate 22/ minute
  Record the patient's condition. Report findings to senior staff nurse.
  The patient's condition will continue to be monitored.

Common action verbs example to be used in nursing care are provide, perform, encourage, educate, explain, teach, measure, assist, etc. Example;

- Provide oral care/ AN care/ PN care
- Perform tepid sponge/EPI program/School Health
- Encourage Range of Motion (ROM) Exercise
- Educate well-balanced nutrition
- Explain the procedure
- Teach drug effects and side effect

CPD Activity Attended from Unregistered CPD Providers

Name:

Duty Station/ Address:

Professional License Number:

Designation:

Professional Registration Number:

Date:

Please complete the CPD provider's information.

1. Title of the CPD Program/ ……………………………………………..………………
2. Brief Description of CPD Activity ……………………………………………………….

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3. Name of the Organization…………………………..………………………………
4. Name of the Trainer……………………………………...……………………
5. Contact information (Organization/Trainer) …………………..………………….

……………………………………………………………………………..……………

……………………………………………………………………………..……………

6. Type of CPD Activities (Theory or Skill based) ……………….………………….

7.Type of Media used for CPD Activity (in-person/ online) ………….…………….

8. If the CPD activity is in-person, place of CPD activity attended ……………….

9. Date attended……………………………………………………………..…………

10. Duration of CPD Activity…………………………………………………………

11. CPD Activity fees ……………………………………………………..……………

12. Certificate provided (Yes/No) ……………………………………….………………

If certificate provided, submit the copy of certificate.

Notification of Approved CPD Points to CPD Provider

Notification of Approved CPD points to CPD Provider

Name of Chief CPD Provider ……………………………..

Institution/ Organization ……………………………………..

CPD Provider Registration Number …………………………….

Registration Period ……………………………………………….

Sr. No.	Name of Trainer/Speaker	CPD Program Tittle	Date Applied	Duration of Program	Proposed CPD point		Approved CPD Point		Remarks
					Theory	Skill	Theory	Skill	

Approved by

……………………………

……………………………

……………………………

Certificate of Recognition for CPD Provider

Certificate of Recognition for CPD Provider

Myanmar Nurse and Midwife Council presents to

……………………………………………………………………

provider registration number

…………………………………………………………

as a recognized CPD provider for conducting activities on

Continuing Professional Development for Nurses and Midwives.

President
Myanmar Nurse and Midwife Council

Date of Issue ……………….
Date of Expiry ……………….

Sample Participant Registration Form

Title of CPD Activity ………………………………………………………… Provider Registration Number …………………………..

Provider's Name ……………………………………………………………… Trainer's Name ………………………………………

Training Venue ……………………………………………………… Date …………………………………

No.	Name of Trainees	License Number	Designation	Duty Station	Signature	Remark

Sample Certificate of Attendance

Certificate of Attendance

This is to certify that

……………(Name)………………………

has attended the

………..……………(Activity Title)………………………………

CPD Point Awarded ……………

Date of Expiry……….

Signature

Provider Name ……………………………

Provider Registration Number …………………

Date………………..

Sample Certificate of Facilitation

Certificate of Facilitation

This is to certify that

……………(Name)………………………

has facilitated the

………..……………(Activity Title)……………………………….

CPD Point Awarded ……………

Date of Expiry……….

Signature

Provider Name …………………………

Provider Registration Number ………………

Date………………..