KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

Program Application for Prior Approval of Education Clock Hours

Mark the appropriate discipline:

ADMINISTRATOR\_\_\_OPERATOR\_\_\_\_ DIETITIANS\_\_\_SPEECH-LANGUAGE-PATHOLOGIST\_\_\_AUDIOLOGIST\_\_\_

**APPLICATION MUST BE RECEIVED BY KDADS 3 WEEKS PRIOR TO THE PROGRAM/ One application per program**

Program Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| Location (City & State) | Dates | Agency Use Only |
| 1 |  | Approval#: |
| 2 |  | Approval#: |
| 3 |  | Approval#: |
| 4 |  | Approval#: |
| 5 |  | Approval#: |
| 6 |  | Approval#: |

Name of Sponsor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Sponsor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Program Coordinator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTACH OBJECTIVES, COURSE CONTENT, AGENDA AND ATTACH INSTRUCTOR QUALIFICATIONS**

Continuing education clock hours exclude time spent on registration, breaks and lunch. Clock hours are awarded in full hour or half-hour increments only for actual continuing education contact time. Individual sessions of fifty minutes of instruction will qualify for one hour, twenty-five minutes for on-half hour. Approval shall not exceed actual clock hours of instruction.

Day 1: From\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ CE Hours Requested\_\_\_\_\_\_\_\_\_\_\_

Day 2: From\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ CE Hours Requested\_\_\_\_\_\_\_\_\_\_\_

Day 3: From\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ CE Hours Requested\_\_\_\_\_\_\_\_\_\_\_

Day 4: From\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_ CE Hours Requested\_\_\_\_\_\_\_\_\_\_\_

Day 5: From\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_ CE Hours Requested\_\_\_\_\_\_\_\_\_\_\_

Day 6: From\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_ CE Hours Requested\_\_\_\_\_\_\_\_\_\_\_

Continuing Education Clock Hours Requested TOTAL

ADMINISTRATOR (Refer to Core of Knowledge subject area list)

1. Administration: Subject Areas 1,2,3,8,9 \_\_\_\_\_\_
2. Resident Care: Subject Areas 4,5,6,7 \_\_\_\_\_\_
3. Electives: Subject Area 10 \_\_\_\_\_\_

Maximum Hours Available \_\_\_\_\_\_\_\_

SPEECH-LANGUAGE PAGHOLOGY AND AUDIOLOGY \_\_\_\_\_

DIETITIAN \_\_\_\_\_

**COPY AS NEEDED**

**For Applications Submitted by Sponsor Sponsor Agrees To:**

1. Attach the program content, objectives, and time frame agenda to application. Incomplete applications will be returned.

2. Record and retain attendance and clock hours.

3. Issue a certificate of attendance/completion to each licensee who attends the program. The certificate will include the sponsor’s name and HOC approval number; the program title, presenter, site and date; the name of the licensee; and the total number of CE clock hours earned by the licensee.

4. Notify HOC in case of program rescheduling, cancellation, or change of instructors.

**For Applications Submitted by Licensee**:

1. Attach the program content, objectives, and time frame agenda to application. Incomplete applications will be returned.

2. Retain all documentation for upcoming license renewal.

The Department will monitor prior approved activities. This may include on-site visits, written inquiries, audits, requests for additional information, and questionnaires.

I verify that the information contained in this application and attachments is accurate and I agree to provide the documentation and notification listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Submitting Application Signature Date

Address, City, State Zip Code Phone number and email address

Send complete form and attachments to: Health Occupations Credentialing

612 S Kansas Ave

Topeka, KS 66603

785-296-1250

[Betty.domer@kdads.ks.gov](mailto:Betty.domer@kdads.ks.gov)

Agency Use Only

Approved\_\_\_\_\_\_ Approved as Modified\_\_\_\_\_\_ Disapproved\_\_\_\_\_\_\_

Change in Core Area\_\_\_\_\_ Change in Clock Hours\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_