Professional Bonus Information Packet

The professional bonus awards are as listed:

•Bonus A award = $1000 •Bonus' B-1 through C = $1500

These awards are taxed as supplemental income per Internal Revenue Status requirements.

Professional Bonus Requirements Overview

The Professional Bonus Program is intended to expose nurses to new learning opportunities and **expand their horizons beyond** what is required or commonly done as a part of their clinical role and job description. As a learning organization, EIRMC encourages both personal and professional growth.

Bonus A: *This bonus is available to all RNs. No specialty certification is required. The RN must show evidence of 16 Contact Hours and completion of six options.*

Bonus B-1: *This bonus is available to all RNs who earned their national certification/recertification in their area of expertise. During the year in which certification/recertification is received, no additional Contact Hours or professional options are required.*

Bonus B-2: *This bonus is available to all RNs who have earned their national certification/recertification in their area of expertise but are in non-recertification years. No additional Contact Hours are required, but six professional options are required.* ***A copy of your present certification must be included with your application.***

Bonus C: *This bonus is available to all RNs who have earned their Bachelors of Science Degree in Nursing &/or Masters Degree in Nursing within the past 12 months. No additional Contact Hours or Professional Options are required. This bonus can be awarded one time for each degree earned. A copy of the diploma must accompany application.*

BONUS	Requirements	Specialty Certification	Contact Hours	Professional Options
A	Available for applicants who do not have a national certification	Not Required	16	6
B-1	Available for applicants who complete their initial specialty certification and during the year of recertification	Required	Contact Hours are included in recertification requirements	0
B-2	Available for applicants during non-recertification years	Required	Contact Hours are included in recertification requirements	6
C	Available when BSN or MS in Nursing is obtained	Not required	0	0

Eligibility Requirements:

The Professional Bonus Program is voluntary. Based on successful completion of required criteria, Registered Nurses are eligible to receive one bonus every 12 months as determined by their approval date.

1. To Participate, RNs must:
   - Have been employed as an RN for 12 continuous months at EIRMC or at another HCA facility. *You must continue to be employed on the date of pay-out in order for the bonus to be paid.*
   - Have completed all hospital and unit orientation requirements within specified unit timeframes.
   - Have successfully completed all hospital and unit-specific mandatory requirements by specified deadlines.
   - Have achieved an average or above average score on the yearly performance appraisal. A re-evaluation may be done 90 days following the initial performance appraisal at the discretion of the unit Director/Manager.
   - Have Manager and/or Director approval.

2. Individuals who are currently involved in unresolved disciplinary action are ineligible to participate in the bonus program.

3. RNs employed as a Manager or Director are not eligible to participate.

4. RN clinical supervisors hired after May 1, 2013 may not participate in Bonus level C as a BSN is a condition of hire for CS role.

Professional Bonus Application Process

To participate in the Professional Bonus Program you must:

1. Determine your eligibility status.

2. If eligible, discuss your intent to participate with your Department Director/Manager. *To receive a bonus you must maintain eligibility.*

3. Complete all of the Professional Options and Contact Hours (if applicable) for the desired bonus while maintaining eligibility status. **A detailed description of Options and Contact Hours follows.*

   Remember that you are responsible for initiating and completing all requirements of the Professional Bonus Program and for ***meeting all associated deadlines****. You are also responsible for collecting and maintaining all required verification materials. All materials must be legible or the entire portfolio will be returned to you.*

   All requirements must be completed within a one-year period of time. *Professional Options and Contact Hours that were completed more than one year prior to the date on the Application for the Professional Bonus Program will not be accepted. Professional Options, Contact Hours and degree(s) earned may be used for one application only.*

4. When all required Professional Options and Contact Hours have been completed, submit your application to your Department Director/Manager. Attach appropriate forms and verifying documents for each activity. *It is your responsibility to meet all deadlines*.

5. The Director/Manager will then submit the entire Application to the ACNO. This is due the Tuesday of the week preceding the meeting (9 days prior). The Professional Development and Education Council will review all materials and either approve or deny the application.

6. Once the application has been approved, or denied, it will be returned to your department. When approved, a copy of the application will be forwarded to Human Resources and a bonus will be issued.

The Professional Development and Education Council

The purpose of the committee is to maintain the quality and consistency of the Bonus Program. To accomplish this, the committee will meet and consider all completed applications every month. The following documents will be reviewed:

- *Application for the Professional Bonus Program* including required signatures.
- Documentation that demonstrates that the applicant has met all requirements.

The documents will be returned to the RN if any of the above are absent or incomplete.

The committee is empowered to approve and deny applications, and will maintain utmost confidentiality.

The committee will:

- Be composed of staff who are members of the Professional Development and Education shared governance council.
- Meet monthly (1st Thursday of the month, unless it's a holiday).
- Review all completed *Applications for the Professional Bonus Program* and agree to either approve or deny.
- Consider appeals
- Review and revise the Professional Bonus Program for Registered Nurses on an annual basis (July).

Appeals Process

It is important that each candidate participating in the Bonus Program be given the opportunity to openly discuss any misunderstandings or problems associated with the bonus program. Appeals and issues should be presented in writing to the Chair of the Professional Development Council at least 2 weeks prior to the next scheduled meeting for review. If it is felt that a conflict exists with presenting an appeal to the PDC, a request to present to the local pay governance committee will be considered on a case by case basis.

Contact Hours

A Contact Hour refers to a variety of educational offerings attended by a RN for the purpose of enhancing his/her professional practice. Unit specific required classes may account for up to 50% of required Contact Hours. The other 50% of the Contact Hours needed in the bonus program must come from non-required activities. Contact Hour applicability is not dependent on who pays for the education**.** A certificate of completion/attendance or official copy of grades is required. A one credit college course can be counted as 15 Contact Hours (likewise a 3 credit course=45 Contact Hours). Page 14. Your Director/Manager or Educator's signature must be on this form to validate that no more than 50% of contact hours are unit specific mandatory requirements.

The following mandatory requirements <u>cannot</u> be counted as Contact Hours:

- Staff meetings
- In-services on new equipment/software
- Yearly house-wide skills labs
- Unit skills labs
- Infection control inservices
- Orientation
- HealthStream required education
- Unit quizzes

Professional Options

OPTIONS *All Options May be Chosen Only Once Unless Indicated Otherwise*	
1	**Participation on a Council/Committee/Task Force:** Hospital or Unit-based Committee or Task Force ▪ Hospital-wide committee assignments are subject to unit director/manager approval and to an opening on the committee. ▪ Attendance at a minimum of 6 committee or task force meetings is required. ▪ May use a combination of committee &/or task forces to meet the minimum requirement of 6 meetings for one option. ▪ Serves as unit representative and provides appropriate input to staff as appropriate. **Committee Member Verification Form – page 15* *May choose this option two times, if two different committees/task forces
2	**Community <u>Health</u> Event** ▪ Must show proof of participation in a health-related activity in the community. ▪ Must be a minimum of four hours of active participation. ▪ May combine hours from more than one community health education experience **Community <u>Health</u> Event Verification Form – Page 16* *May choose this option two times, if two different occurrences
3	**Unit Based Class/In-service** ▪ Presentation must be 20 minutes long. ▪ Topic and written objectives must be approved by unit director/manager/clinical educator prior to inservice ▪ Research will utilize at least two sources with bibliography included **Unit-based Class/Inservice Form – page 17*, *Attendance roster*, *Summary of Evaluation Forms – pages 18,19 (with evidence of above average scores)* *May choose this option two times if on different topics

4	**Preceptor for students, Licensed Personnel, or Student Interns** ▪ Must have completed a nursing preceptor class – provide the date attended, or a copy of the course certificate. ▪ Precept a minimum of 120 hours per year **Preceptor Log – page 20, must have Director/Manager signature*
5	**Float Nursing** ▪ Minimum 48 hours per year. (Float Pool, Pediatrics to PICU, TCU and Rehab, IMC to Cardiac step down and ISC to 3rd Surg/Ortho are ineligible) **Float Log – page 21, must have Director/Manager signature*
6	**Major Revision or Development of New Policy/Standard of Practice** ▪ Pre-approval required by Unit Director/Manager ▪ In accordance with hospital format ▪ Change supported by literature search in related field. ▪ Interdisciplinary Practice Council (IDPC), departmental or physician committee approval is required. ▪ *May choose this option twice* ▪ Minor policy revisions do not qualify. **Policy/Standard of Practice Development or Revision Verification Form – page 22* **Reference List* **Copies of new, original and revised policy(ies) with changes highlighted*
7	**Competency Super User (Arterial Puncture Preceptor Class/Blood Glucose Monitor Trainer/POC Testing (iSTAT)/Fit Tester/Education Liaison)** ▪ Completes Arterial Puncture Preceptor Class/BGM Trainer/Fit Tester Training ▪ Precepts minimum of 5 times per year; trains minimum 10 on BGM; performs 10 Fit Tests per year. ▪ Education Liaison - Validates competency on a minimum of 10 employees (education dept will determine what competencies and time frame of completion—work with your educator or manager/director) *Must include (as applicable)*: • *Proof of completion of Arterial Puncture Preceptor Course BGM Trainer Course/Fit Tester Training* • *Proof of Education Liaison competency (from educator)* • *Arterial Puncture Check list for each preceptee – page 23* • *POC/BGM Log/ Fit Test Log/Competency Validation log – pg 24*

8	**Professional Healthcare Organization/ Membership** ▪ Must show proof of current membership **Copy of valid card*
9	**Professional Healthcare Organization/ Officer** ▪ Must perform duties as appropriate to office/membership ▪ Must show involvement such as attendance at local/ national meetings, conference, or electronic communication **Must present proof of participation (i.e. agenda, meeting minutes)*
10	**Successful Completion of an Acceptable College Course** ▪ Must be nursing related ▪ Acceptability determined by PBC. ▪ Must be a 3 credit class (or combination of a total of 3 credits). ▪ *May use up to 3 times annually* **Submit copy of documentation of passing grade with application and curriculum, if applicable.* ****Cannot also be used for level specific Contact Hours/LU***
11	**Chart Review** ▪ A minimum of 30 charts or 4 hours worth must be reviewed - ***does not include reconciliation audits (i.e. Pyxis)*** ▪ Director/Manager must approve prior to actual review ▪ List chart review objectives or goals ▪ Were the objectives or goals met? If not, why? ▪ The data must be analyzed with findings and recommendations noted on verification form. ******* *Chart Review Verification Form – page 25*

12	**Performance Improvement Project - Initiation/Coordination/Development of a Unit based project** ▪ Identifies a unit project ▪ Must be pre-approved by Unit Director/Manager ▪ Designs a study ▪ Implements data collection for one quarter (minimum 3 months) ▪ Tabulates data results ▪ Formulates conclusions ▪ Reports findings appropriately ▪ Final project will be approved by unit director/manager/clinical educator after above criteria met ***May be counted as 2 options*** **Unit Based P.I. Project Verification Form – page 26*
13	**Bulletin Board - Community/Patient/Staff Education** ▪ Topic must be pre-approved by Director/Manager/Clinical Educator or Professional Bonus Committee ▪ Objectives must be listed ▪ A minimum of 2 professional references are required ▪ Display must be verified by approver ▪ Attach a photo of the completed board **Bulletin Board Verification Form – page 27 photo of bulletin board*
14	**Development/Presentation of Skills Lab or Teaching Nurse Residency** ▪ In collaboration with Education Department or unit based ▪ Minimum of 4 hours of participation ▪ Can include up to one hour of prep time ▪ Must be competency based *******Skills Lab/Residency Teaching Presentation Verification Form – page 28* * May choose this option two times if different topic – Any combination of hours
15	**Patient Education Plan - Develops**: ▪ Must be pre-approved by Unit Director/Manager/Clinical Educator ▪ Submit written teaching plan for an identified patient population ▪ The education plan must include an assessment, objectives, teaching strategies, references ▪ Must be shared with staff members and implemented in the hospital setting **Patient Education Plan Verification Form – page 29*

16	**Development of Staff Self-Learning Packet** ▪ Some ***examples*** of self-learning packets are: Safety Book, Moderate Sedation Self Study, Restraint Self Study, etc ▪ Must be pre-approved by unit director/manager/clinical educator ▪ Must include objectives, references (at least 2), and test ▪ Information must be synthesized from the resources used ▪ Evaluation is based on appearance, content, clarity, and accuracy of the self-learning packet ▪ Minimum of five people must complete the packet including evaluation. **Self Learning Packet Form – page 30*
17	**Course Instructor – Successfully completes Instructor Course & or Instructs in Course required number of times** ▪ NRP, BLS, PALS, ACLS, ACLS EP, FHM, STABLE, TNCC, ENPC, Nonviolent Crisis Intervention (NVCI), Oncology Nursing Society (ONS) ▪ Must be nationally affiliated ▪ Teach in accordance with course standards ▪ Teach required number of classes per year to maintain instructor status – *example: NRP requires that 2 classes be taught in 2 years* ▪ *Copy of instructor card and Course Instructor Verification Form – pg 31* *May choose this option two times for two different courses (i.e. ACLS and PALS—not 2 different PALS classes).
18	**Minimum of three years of continuous at EIRMC** *May choose this option one time every year. **Attach Verification of Continuous Employment Form – page 32*
19	**Special Project – Unit based/hospital wide** ▪ A proposal must be written and approved by Unit Manager/Director prior to initiating a special project. ▪ Must demonstrate acquisition and utilization of clinical and professional research to implement a change in practice, ▪ **Or** identifies an area for improvement and after a thorough investigation recommends/implements a change, ▪ **Or** special project may be initiated by Unit Manager/Education Coordinator ▪ **Depending on the scope of the project, this may count as more than one option. Prior approval from Professional Bonus Committee is required if requesting more than one option.** ***The following is an <u>example</u> of a special project:*** Team Leader of a Hospital Wide Performance Improvement Team ▪ Hospital Quality Improvement Committee (QI) approves and directs

	▪ Reports quarterly to committee ▪ Interfaces with Medical QI ▪ Provides/Coordinates house wide education ▪ Develops/Implements new forms ▪ Tabulates/formulates conclusions ▪ Report findings ▪ Literature review, budget analysis, etc **Special Project Verification Form – page 33* May choose this option 2 times if different project
20	**Narrative that demonstrates Critical Thinking** Narrative written about any situation that demonstrates critical thinking. Narrative must be typewritten and contain the following elements: ▪ Include verifiable information – date, time, diagnoses, age, ▪ Appearance before committee may be requested, ▪ Criteria: Identify a problem Signs and symptoms of problem Immediate interventions taken Potential causes leading to problem Additional interventions done (Did they work?) Notification of appropriate personnel Did interventions work? Reflection back on events taken place What circumstances led to this event? Did I prioritize my interventions appropriately? Were my actions effective? What could have been done differently, if anything ▪ *Submit copy of narrative to Professional Development Council* *******This will not be returned and may be published for internal use*******
21	**Poster Presentation at a Regional or National Conference** ▪ Must submit detailed expectations/guidelines of poster to include objectives and references ▪ Participant evaluation is required if available Poster Presentation at Regional Conference = 2 options Poster Presentation at National Conference = 3 options **Must submit list of objectives, photo of poster, and Summary of Evaluation Form – if available.*

22	**Professional Presentation at a Regional or National Conference** ▪ Must submit actual lecture, objectives handouts and references used ▪ Participant evaluation is required Presentation at Regional Conference = 2 options Presentation at National Conference = 4 options **Must submit copies of lecture, objectives, handouts, references, and Summary of Evaluation Forms*
23	**Nursing Research – Primary Researcher** ▪ Pre-approval by Nursing Research Council and followed by Institutional Review Board (IRB) approval if needed ▪ Review and follow requirements detailed in Institutional Review Board Policy ▪ Perform a literature search using available resources ▪ Identify a problem ▪ Formulate a hypothesis ▪ Design study according to accepted research guidelines, with appropriate sample size ▪ Collect data, evaluates reliability/validity of measurement ▪ Analyze data – content analysis, summary of data in charts, graphs, tables, correlates relationship of data and statistical analysis ▪ Formulate conclusions and/or recommendations ▪ Summary report of all aspects of literature search, study design, data collection, analysis, and conclusions, and bibliography ▪ Submits final report to IRB The primary researcher may count for 6 options *This project may take longer than one year **Must submit copy of entire research project*
24	**Nursing Research – Secondary Researcher** ▪ Major participation in research protocol that follows above guidelines but is done under direction of primary researcher. ▪ Data gathering alone does not qualify. **Will count as 2 options** ** Must submit copy of research project and a signed statement by primary researcher verifying secondary researcher's level of involvement.*

25	**Nursing Research—Publish** ▪ Publication of a nursing research project in a recognized nursing journal Will count a **3 options** **Must submit a copy of the article and proof of publication.*
26	**Publish Article (non-research)** ▪ Publication of a nursing topic article **Must submit a copy of the article and proof of publication.*
27	**Prevalence Study/Infection Control Surveillance Module Participation** ▪ Must demonstrate active participation in a Prevalence Study ▪ Must demonstrate active participation in Infection Control surveillance module participation (work with Infection Control nurse) May choose this option 2 times, if two different prevalence studies/IC modules *Must submit: Prevalence Study/IC Module form – page 34*

EASTERN IDAHO REGIONAL MEDICAL CENTER

APPLICATION FOR PROFESSIONAL BONUS PROGRAM

NAME:_____Dept #___ _____ DATE:_____ _ _____

Applying for Bonus: A __ B-1 __ B-2 __ C __ Your job title/role:_____

Hire Date: _____Date of last bonus: _____

Number of Contact Hours Completed: _____ **See attached Education Log*

Option # _____
Activity: _____ *Date completed:* _____

Option #_____
Activity: _____ *Date completed:* _____

Option #_____
Activity: _____ *Date completed:* _____

Option #_____
Activity: _____ *Date completed:* _____

Option #_____
Activity: _____ *Date completed:* _____

Option #_____
Activity: _____ *Date completed:* _____

**Attach Copy of Certification Card, Bachelors or Masters Degree*

I verify that all information on this application is accurate.

_____ DATE_____
Applicant

☐ I approve this application

_____ DATE_____
Manager/Director

Application is ____ Approved ____ Denied Bonus: _____

_____ DATE_____
Professional Bonus Committee

EDUCATION LOG

Name:_____

Date	***Title***	***Presenter***	***Contact Hours***	***Mandatory?*** *Yes or No*

Attach verification

Total Contact Hours:_____

Manager/Director/Educator signature:_____

(Signature indicates that unit specific required classes do not account for more than 50% of contact hours)

OPTION 1
COMMITTEE/TASK FORCE MEMBER VERIFICATION

Name(s) of Committee/Task Force: _____

_____

Dates of meetings attended: ***Minimum of 6 are required***

_____

_____

_____

_____

Chairperson signature(s): _____

_____

_____

_____

Director/manager Signature and date: _____

OPTION 2

COMMUNITY HEALTH EVENT VERIFICATION

I verify that: _____
Name

Participated in: _____
Name of Event

_____ for a total of _____hours.
Date

_____ _____
Signature – Event Facilitator Date

_____ _____
Participant Date

OPTION 2

COMMUNITY HEALTH EVENT VERIFICATION

I verify that: _____
Name

Participated in: _____
Name of Event

_____ for a total of _____hours.
Date

_____ _____
Signature – Event Facilitator Date

_____ _____
Participant Date

OPTION 3

UNIT-BASED CLASS/INSERVICE RECORD FORM

Note: Director/Manager Pre-approval is required.

Name:

Topic:

Objectives:

Pre-Approval Required Signature:

_____ _____

Director/Manager Signature Date

Content Outline:

Professional References: *(2 sources are required)*

1.

2.

Dates presented: *(include length of actual presentation)*

Total Attendance: (*attach Attendance Roster)*

Director/Manager Final Approval: _____

OPTION 3

UNIT-BASED CLASS/INSERVICE EVALUATION FORM

Course Title:

_____

Presenter: _____

Date: _____

For the following questions, circle the number which most closely corresponds to your opinion of the offering. Circle only one response for each question.

	Poor	Fair	Good	Outstanding
1: What is your overall evaluation of this offering?	1	2	3	4
2: To what extent were your expectations met regarding offering content?	1	2	3	4
3: Were the offering objectives met?	1	2	3	4
4: Rate the overall presentation of the speaker.	1	2	3	4
5: Did the offering provide new information?	1	2	3	4
6: Did the speaker allow sufficient time for questions and answers?	1	2	3	4
7: Did the offering provide a quality continuing education experience?	1	2	3	4

Comments:

OPTION 3

UNIT-BASED CLASS/INSERVICE

SUMMARY OF EVALUATION FORMS

Course Title: _____

Presenter: _____

Date: _____ Number of Evaluations Received_____

Please enter the percentage of total evaluations received to the right of each item below:

	Poor	Fair	Good	Outstanding
1: What is your overall evaluation of this offering?	1_____%	2 _____%	3 _____%	4 _____%
2: To what extent were your expectations met regarding offering content?	1_____%	2 _____%	3 _____%	4 _____%
3: Were the offering objectives met?	1_____%	2 _____%	3 _____%	4 _____%
4: Rate the overall presentation of the speaker.	1_____%	2 _____%	3 _____%	4 _____%
5: Did the offering provide new information?	1_____%	2 _____%	3 _____%	4 _____%
6: Did the speaker allow sufficient time for questions and answers?	1_____%	2 _____%	3 _____%	4 _____%
7: Did the offering provide a quality continuing education experience?	1_____%	2 _____%	3 _____%	4 _____%

Comments: (Please copy all participant comments below)

OPTION 4
PRECEPTOR LOG

NAME_____DATE OF PRECEPTOR CLASS_____

NAME	DATE	SCHOOL or UNIT	HOURS	COMMENTS

TOTAL HOURS: _____

Manager/Director/Educator signature:_____

Option 5

FLOAT LOG

Name: _____ Home Dept. _____

Department	Date	# Hours	Comments

Total Hours _____

Manager/Director/Educator signature:_____

OPTION 6

POLICY/STANDARD OF PRACTICE DEVELOPMENT OR REVISION VERIFICATION

I verify that _____ has developed or revised
(circle correct choice)

Policy/Standard of Practice: _____ #: _____

Reason for developing or revising existing policy/standard: _____
_____
_____
_____
_____

Policy/standard content is based on the following: (i.e. research study, references, Standard of Practice) _____
_____
_____
_____

Policy/standard was approved by the following committee(s):
_____
_____
_____

on _____, 20_____.
Date

**Attach copies of original and revised policy with changes highlighted.*

_____
Signature – Approval Committee Chairperson

_____
Date

OPTION 7

ARTERIAL PUNCTURE CHECKLIST

Name:_____ Date:_____

PASS	FAIL	
_____	_____	Check physician's order
_____	_____	Gather equipment
_____	_____	Explain procedure to patient/family
_____	_____	Check collateral circulation (Allen's test for radial site)
_____	_____	Prepare syringe
_____	_____	Don gloves – mask and eye shield as indicated
_____	_____	Prep site and gloved fingertip with betadine
_____	_____	Locate and bracket artery
_____	_____	Puncture artery; collect 1.5 to 3 ml blood
_____	_____	Remove excess air, recap needle using one-handed technique or mechanical recapping device and replace capped needle with a black stopper
_____	_____	Apply firm, constant pressure for 5-15 minutes
_____	_____	Agitate sample 20-30 seconds
_____	_____	Send labeled, iced specimen in bag immediately to Laboratory
_____	_____	Recheck circulation every 15 minutes X 1 hour

_____
Signature – Preceptor

_____
Arterial Puncture Site

Option 7

POC Testing/Blood Glucose Log/Fit Test Log/Competency Validation Log

Name:_____

Date	***Name of individual trained/tested/validated***	***Dept***

Manager/Director/Educator signature:_____

OPTION 11

CHART REVIEW VERIFICATION

I verify that _____ reviewed _____
Name Number

or charts OR _____for P.I. purposes which I approved.
Hours

1. Objective/Goals

2. Were Objectives/Goals Met?

3. Data Analysis:

4. Findings/Recommendations based on data analysis:

_____
Signature –Unit Director/Manager

_____
Date

OPTION 12
UNIT BASED PERFORMANCE IMPROVEMENT PROJECT VERIFICATION

Name:

Topic:

Describe the PI Project: _____

Director/Manager Pre-Approval/Date: _____

Highlight details of the study conducted: _____

Data Collection Dates: _____

Data Results Summary: _____

Conclusions: _____

To whom reported/Dates: _____

Director/Manager Final Approval/Date:_____

OPTION 13

Bulletin Board Verification Form

Name:

Title of Bulletin Board:

Objectives:

Professional References:

Pre-approval Signature: _____ Date: _____

Dates posted:

Where posted?

Verification signature: _____ Date: _____

*Attach a photo of the completed bulletin board

OPTION 14

SKILLS LAB/Residency Teaching PRESENTATION VERIFICATION

I verify that _____ presented a station/taught in the
Name

_____ Skills Lab/Residency training held on _____,
Unit Date

20_____, teaching for a total of _____ hours.

Topic Presented: _____

_____
Signature – Skills Lab/Residency Facilitator

_____
Date

SKILLS LAB/Residency Teaching PRESENTATION VERIFICATION

I verify that _____ presented a station/taught in the
Name

_____ Skills Lab/Residency training held on _____,
Unit Date

20_____, teaching for a total of _____ hours.

Topic Presented: _____

_____
Signature – Skills Lab/Residency Facilitator

_____
Date

Option 15

PATIENT EDUCATION PLAN VERIFICATION

Name:

Title of Patient Education Plan:

Diagnosis or demographics of patient population addressed:

Assessment: (How was need determined?):

Objectives:

References used:

Teaching Strategy (What will be done to teach the patient population the desired information?)

Implementation (How will the information be conveyed to the patients?)

Target Date for Implementation:

How was the plan shared with staff members?

_____ _____

Pre-Approval Signature
Unit Director/Manager/Clinical Educator

Unit Director/Manager/Clinical Educator

_____ _____

Date

Date Plan was implemented on the Unit

OPTION 16

SELF LEARNING PACKET VERIFICATION

Name:

Topic:

Objectives:

_____ _____

Pre-Approval Signature Date
Unit Director/Manager

References:

Who completed the packet? Participant test score

Unit Director/Manager: Please evaluate this packet on the basis of:

- Appearance
- Content
- Clarity
- Accuracy

_____ _____

Final Approval Signature Date
Unit Director/Manager

OPTION 17

VERIFICATION OF COURSE INSTRUCTOR

FOR PROFESSIONAL BONUS PROGRAM

Employee name: _____

Course certified to be an instructor in:

_____

Dates of classes taught:

_____

_____

Did the instructor's class evaluations meet acceptable standards? Y or N (circle one)

Does the instructor meet the requirements of this specific course? (*For example, NRP requires that 2 classes be taught in 2 years*)
Y or N (circle one)

Signature of education department representative:

_____

(A separate form is required for each course as this option may be used as two options for two different courses)

OPTION 18

VERIFICATION OF CONTINUOUS EMPLOYMENT

FOR PROFESSIONAL BONUS PROGRAM

Employee Name: _____

Continuous Service Years:_____

Human Resource Representative: _____

Date*:* _____

Option 19

SPECIAL PROJECT VERIFICATION FORM

Name:

Describe Special Project:

- Purpose
- Implementation Plan
- Estimated cost (man hours, supplies, equipment, etc.)
- Projected completion date:

Director/Manager Pre-Approval Signature /Date: _____

Describe actual outcome/results of Project:

- Implications for department/hospital
- Actual cost (manhours, supplies, equipment)
- Actual completion date

Director/Manager Final Approval Signature/Date: _____

Option 27

PREVALENCE STUDY/IC MODULE VERIFICATION

I verify that _____ actively participated

In the following Prevalence Study/IC module _____

Purpose of Prevalence Study/IC module: _____

_____

_____

_____ _____

Signature – Facilitator Date

_____ _____

Signature – Participant Date