Appendices: Verification Forms

Please use one form per activity

These forms may be used to document participation in activities for which Contact Hours may be earned. These forms may be photocopied.

APPENDIX D: VERIFICATION OF QUALITY CARE ACTIVITY FORM

____

I VERIFY THAT (NAME)

has written a/an:

- ◯ Standardized nursing care plan
- ◯ Nursing policy, directive, procedure, or protocol
- ◯ Flowsheet, chart, patient assessment tool
- ◯ Informal aid intended for reference by staff
- ◯ Patient educational aid, booklet or audio visual program
- ◯ Evaluation tool based on outcome criteria

has served as/developed:

- ◯ Unit-based committee
- ◯ Hospital-wide committee

____

NAME/TITLE OF ACTIVITY OR COMMITTEE

____

DATE(S) OF ACTIVITY

____

SIGNATURE　　　　EMAIL ADDRESS　　　　TELEPHONE NUMBER

____

TITLE OF PROGRAM COORDINATOR, CLINICAL MANAGER/DIRECTOR, OR CPAN®/CAPA® CERTIFIED COLLEAGUE　　　　DATE

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