



## SINGLE EDUCATIONAL OFFERING APPLICATION

*For Continuing Education Points for Transplant Certification*

**Title of Offering:** \_\_\_\_\_

The following items are enclosed with this application:

- Program Goal
- Target Audience
- Learning Objectives
- Teaching Methodology
- Participant Roster
- Evaluation Tool
- Certificate of Attendance
- Faculty Credentials

A Faculty Data Form or curriculum vitae must be included for each presenter.

- Fee Enclosed-\$250 for all single offerings **plus \$200 rush fee (10 days or less prior to conference date)**

- Check
- Credit Card
- MasterCard
- Visa
- American Express

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Code: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_

### AFFIDAVIT OF SUBMITTING INDIVIDUAL

Individual Submitting Application: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

I CERTIFY THAT I HAVE REVIEWED THE CONTENTS OF THIS APPLICATION PACKET AND SAID CONTENTS ARE TRUE AND CORRECT.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Send this form to:**

info@abtc.net  
856-439-0525

**APPLICATION INSTRUCTIONS :**

- a. Type or print all information
- b. Complete all sections of the application
- c. Number all pages sequentially
- d. Identify all attachments with applying organization/agency name
- e. Enclose **one single sided copy of all materials**
- f. Enclose payment

**SINGLE EDUCATION OFFERING APPLICATION**

**SECTION I – General Information**

- 1. Applying Organization/Agency \_\_\_\_\_  
Address (to which the confirmation letter should be mailed) \_\_\_\_\_  
Telephone Number \_\_\_\_\_
- 2. Course Director \_\_\_\_\_  
Title \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Email Address: \_\_\_\_\_

**SECTION II – EDUCATIONAL OFFERING DATA**

- 1. Title of Offering \_\_\_\_\_
- 2. Date(s) of Offering \_\_\_\_\_  
 Online  Webinar  Conference Call
- 3. Location of Offering \_\_\_\_\_  
Facility/City/State
- 4. Category & Number of CEPTCs Requested \_\_\_\_\_
- 5. Target Audience \_\_\_\_\_

6. Learning Objectives:
- Clinical relevance to donation and transplantation
  - Applicability to safe, effective, efficient quality care
  - Process improvement for timely care
  - Quality outcomes
  - Patient and family education
  - New therapies or technologies
  - Disease management
  - Other transplant related education
7. Content: \_\_\_\_\_ See attached brochure  
 \_\_\_\_\_ Complete Summary of Professional Education Content
8. Selection of Teaching Methods; (Mark all that may apply):
- Lecture
  - Panel discussion
  - Question and Answer
  - Hands on workshop
  - Round Table
  - Case presentation
  - Other: \_\_\_\_\_
9. Selection Criteria for Program Planning Individual(s) or Committee members:  
 See Attached CV or resume for each person, (one committee member must be ABTC Certified)  
 Please list below individual(s) serving as course directors or planning committee members for your organization's educational offerings:

_____ Name/Title	_____ Certification
_____ Name/Title	_____ Certification
_____ Name/Title	_____ Certification
_____ Name/Title	_____ Certification
_____ Name/Title	_____ Certification
_____ Name/Title	_____ Certification

**AMERICAN BOARD FOR TRANSPLANT CERTIFICATION**  
**1120 Route 73, Suite 200**  
**Mount Laurel, NJ 08054**  
**856-437-4662**  
**Fax: 856-439-0525**

**OFFERING DATA CHART**

**OFFERING TITLE** \_\_\_\_\_ **SPONSOR** \_\_\_\_\_

<i><b>OBJECTIVES</b></i>	<i><b>CONTENT</b></i>	<i><b>FACULTY</b></i>	<i><b>TEACHING METHODS</b></i>
<b>List objectives in operational/behavioral terms.</b>	<b>List each topic area to be covered and provide a description or outline of content</b>	<b>List presenter(s) for the topic.</b>	<b>Describe the teaching method(s) used for each session.</b>

**PARTICIPANT ROSTER  
 AMERICAN BOARD FOR TRANSPLANT CERTIFICATION  
 1120 Route 73, Suite 200  
 Mount Laurel, NJ 08054  
 856-437-4662  
 Fax: 856-439-0525**

Title of Offering \_\_\_\_\_

Dates \_\_\_\_\_ Approval Number \_\_\_\_\_ Category \_\_\_\_\_ CEPTCs \_\_\_\_\_

Applying Organization/Agency \_\_\_\_\_

Address \_\_\_\_\_

Offering Site \_\_\_\_\_

Single Offering  Web  Other

Address \_\_\_\_\_

Brief description of offering: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Participant must either include at least the last 4 digits of SSN OR their entire certification #.

	<b>Print Name</b>	<b>Signature</b>	<b>ABTC Certification #</b>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____
16.	_____	_____	_____
17.	_____	_____	_____
18.	_____	_____	_____

**THIS FORM MAY BE DUPLICATED AS NECESSAR**

**American Board for Transplant Certification®**

 1120 Route 73 · Suite 200 · Mount Laurel, NJ 08054

 856.437.4662  856.439.0525  [abtc.net](http://abtc.net)  [info@abtc.net](mailto:info@abtc.net)