American Board for Transplant Certification
4400 College Blvd, Suite 220
Overland Park, KS 66211
913.222.8662 phone | 913.222.8606 fax
abtc-info@kellencompany.com | www.abtc.net

Approved Provider Application
Continuing Education Points for Transplant Certification

Applying Organization Agency: _____

The following items must be enclosed in order for the application to be considered complete:

☐Completed Application Form

Attachments

☐Sample Participant Roster
☐Sample Certificate of Attendance
☐Sample Program Brochure
☐CV/resumes of planning committee (at least one member of the committee must be ABTC Certified)
☐Non-Refundable Application fee ($1500 annual fee which includes unlimited amount of offerings during the year)

AFFIDAVIT OF SUBMITTING INDIVIDUAL

Date: _____

Individuals Submitting Application: _____

Title: _____

Telephone Number: _____ Fax Number: _____

Email: Address: _____

I certify that I have reviewed the contents of this application packet and its contents are true and correct and adhering to ABTC's standard (see recertification application)).

Signature: _____

Send this form and the supporting documentation to:

American Board for Transplant Certification
4400 College Blvd, Suite 220
Overland Park, KS 66211
Phone: 913.222.8662 Fax: 913.222.8606

Application Instructions

a. Type or neatly print all information
b. Complete all selections of the application and attach any necessary documents
c. Attach a copy of provide a brief summary where policies/procedures are requested
d. Enclose payment

Approved Provider Application

Applying Organization/Agency: _____

Address: _____
P.O. Box or Street Address

_____
City/State/Zip

Telephone: _____

Administrative Contact: _____

Email Address: _____

Address (if different from above): _____

_____

Telephone (if different from above): _____

Method of payment: ☐Check/Money Order (Made payable to ABTC) FIN #48-1058372
☐VISA ☐MasterCard ☐American Express

Cardholder Name: _____ Card Number: _____

Exp. Date: _____ Signature on Card: _____

Description of applying agency:

☐Professional Society
☐Tissue Bank
☐Hospital
☐Voluntary Health Org.
☐OPO
☐Eye Bank
☐College/University
☐Other:
_____

If "Other" is marked please attach a descriptive statement of sponsoring agency

Is sponsoring agency a department, division, or subsidiary of another organization?
Yes ☐ No ☐

If yes, describe relationship: _____

Is your organization an approved provider of CME?

- ☐ Yes, please provide CME provider number, documentation of approved status and move on to providing the list of Program Committee Members.
- ☐ No, complete entire application.

The learning objectives will address the following (Check all that apply):

- ☐ 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 of technologies
- ☐ Disease management
- ☐ Other transplant related education

Selection of teaching methods: What method(s) will be used? (Mark all that apply)

- ☐ Lecture
- ☐ Panel discussion
- ☐ Question and answer
- ☐ Hands on workshop
- ☐ Round Table
- ☐ Case presentation
- ☐ Enduring Material
- ☐ Other:

_____

Development of Content: What method(s) are used to determine need for content? (Mark all that apply)

- ☐ Survey of potential learners
- ☐ Evaluations from previous CEPTC activities
- ☐ Needed health outcomes
- ☐ Identified new skills
- ☐ Literature review
- ☐ Quality improvement data
- ☐ Federal/state mandate
- ☐ Other:

_____

☐ Development of evaluation tool: Provide sample evaluation tool

☐ Submit (attach) a copy of one program brochure or agenda for an educational offering what was conducted within the last 12 months.

Selection Criteria for Program Planning Individual(s) or Committee Members:

See Attached abbreviated CV and/or Biographical sketch for each person, (one committee member must be ABTC Certified)

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

Participant Attendance:

Note: A participant Roster must be maintained for each offering.

Target Audience _____

☐Certificate of Attendance: Provide a sample

This form may be duplicated as necessary. This form is to be turned in when submitting a new offering for credits. This is only documentation that must be submitted with the brochure/agenda. Please email or fax this form and the meeting agenda/brochure to ABTC at the fax number or email to abtc-info@KellenCompany.com

Offering Title: _____

Approval Number: _____

Approved Provider: _____

Please provide at least 2 learning objectives _____

_____

_____

Course Directors: _____
Name/Title

_____

Planning Committee Members: _____
Name /Title

_____

Location(s) of Offering: _____
Facility/City

Date(s) of Offering: _____

Delivery method of offering, e.g. multiple dates, single offering, web delivery: _____

_____

Category ☐ I ☐ II ☐ III Number of CEPTCs requested: _____

Affidavit of Submitting Individual

Individual Submitting Form: _____

Title: _____

Telephone Number: _____ Email: _____

I certify that the above offering was conducted according to the specifications of the original application, which was approved by the ABTC.

_____ _____
Signature Date

Send this form to:

American Board of Transplant Coordinators
4400 College Blvd, Suite 220
Overland Park, KS 66211
Phone: 913.222.8662 Fax: 913.222.8606
Web Site: www.abtc.net E-mail: abtc-info@KellenCompany.com

Attach a copy of the offering brochure. This form may be duplicated as necessary.