STATE BOARD OF NURSING
P.O. BOX 2649
HARRISBURG, PA 17105-2649

PHONE: 833-367-2762
FAX: (717)783-0822
www.dos.pa.gov/nurse
Email: st-nurse@pa.gov

INFUSION THERAPY EDUCATION PROGRAM APPLICATION FOR APPROVAL

- Review Sections §21.141, §21.145, §21.145a, §21.145b and §21.203 of the Board's regulations to develop this Program.
- The application should be submitted by mail at least **90 days prior** to the start date. Board approval is required prior to offering.
- Attach the non-refundable fee of **$285.** Make the check or money order payable to the "Commonwealth of Pennsylvania" and mail it with this application to the above address.
- Providers shall maintain records of attendance.

NOTE: If this Program is intended for CE credit for RNs use the ***Application for Approval as a Provider of RN Continuing Education*** found at: https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Nursing/Pages/Continuing-Education.aspx.

Complete the following information (please print):

Name of Provider:
Address of Provider:
Telephone Number / Fax / Email / Web Address of Provider: **( ) FAX**
Name of RN Responsible for Program:
Address of RN Responsible for Program:
Telephone Number / Fax / Email of RN Responsible for Program: **( ) FAX:**

Title of Infusion Therapy Education Program:
Date(s) and Location(s) of Program:
Number of Hours: : **Target Audience:**

Attach the following documents:

1. Faculty Qualification Form: Use **Template 1** (Submit this form for each faculty member listed).

2. Syllabus: Use **Template 2.**

3. Certificate of Completion: Use **Template 3.**

4. Participant Evaluation Form Developed by Provider

Number all Pages.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911. I also verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration or the denial/restriction of the approval to be a nursing education program.

_____

(Signature of RN Responsible for Program)