



## MULTIPLE EVENT PROVIDER (MEP) APPLICATION FORM

Credentialing Excellence in Health Education

---

*This application form may be reproduced on your own computer software. Please follow the format below.*

### Part I: Provider Information

Tax ID # \_\_\_\_\_

Organization Name \_\_\_\_\_

Period of Designation Requested:  2 years  4 years

Date Designation to Begin:  January 1, \_\_\_\_\_  July 1, \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

E-mail \_\_\_\_\_

Would you like your organization listed on NCHEC's Web site? \_\_\_\_\_ YES \_\_\_\_\_ NO

How should CHES/MCHES register for your programs? \_\_\_\_\_

---

### Part II: Organizational Resources [Attach additional pages as needed.]

1. Purpose/Mission of Organization:  
Describe in 100 words or less your organization's mission as it relates to providing continuing education in health education. (Attach additional pages as needed)
2. List your two most recent NCHEC-approved continuing education event(s) **OR** attach evidence of current designation as a continuing education provider for another health profession.
3. Briefly describe the organization group or management unit responsible for continuing education in health education. Please attach an organization chart showing the placement of the continuing education activities. List members of this management unit. At least one member must be an active CHES/MCHES.
4. Describe the processes and resources that the organization will use to ensure quality control for the continuing education events/programs to be offered. Please limit the description to four pages or less.
  - a) Designated staff or funds for the activities
  - b) Communication channels with affiliates (if applicable)
  - c) Record keeping responsibilities (Who will keep records and where? How will you ensure that accurate records are maintained for a minimum of five years and that reports are submitted to NCHEC as required?)
  - d) Approval process and criteria for developing programs

### Part III: System for Program Development and Implementation

Organizational structure for delivery of continuing education:

1. Who will be responsible for planning and offering programs?  
 Applicant       Affiliates       Both
2. If affiliates are part of the proposed delivery system for the programs to be offered, please provide the following Information:
  - a) Total number of affiliates
  - b) List of every participating affiliate
3. What is the potential geographic area for offering programs?
4. Do you plan to co-sponsor programs with other organizations? If so, identify potential other organization(s).
5. Describe any ongoing assessment to assure that programs offered remain relevant to the needs of CHES/MCHES.

### Part IV: Assurances

The following criteria will be addressed for each program offered by           (Organization Name)          :

- A CHES/MCHES will be actively involved in the planning process
- A thorough assessment will be conducted to determine the need for each program
- Learning objectives will be clearly defined as they relate to at least one of the Areas of Responsibility for entry-level CECH
- Learning objectives will be clearly defined as they relate to at least one of the Sub-competencies for advanced-level CECH
- An evaluation will be conducted to assure quality program delivery (attach sample)
- A Certificate of Attendance/Completion will be awarded to reflect the accurate number of entry- and advanced-level continuing education contact hours (CECH) earned by each CHES/MCHES participant

Signature of Leadership Representative \_\_\_\_\_

Title \_\_\_\_\_ Telephone \_\_\_\_\_

## Part V: Payment

You may submit a purchase order, check or money order made **payable to NCHEC**, or complete the credit card information below. The following fee scale is in effect:

<u>Affiliates</u>	<u>2 years</u>	<u>4 years</u>
0	\$ 500	\$ 900
1+	\$ 750	\$1,350

**Payment Amount Authorized:** \_\_\_\_\_

**Check One:**

\_\_\_\_\_ VISA    \_\_\_\_\_ MasterCard    \_\_\_\_\_ Discover    \_\_\_\_\_ American Express

**Card Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Exp Date:** \_\_\_\_/\_\_\_\_

**Cardholder's Name** \_\_\_\_\_

**Authorized Signature** \_\_\_\_\_

**Billing Address** \_\_\_\_\_

---

**Please submit the application, with attachments and appropriate payment to:**

**Mail: National Commission for Health Education Credentialing, Inc.  
ATTN: Continuing Education Coordinator  
1541 Alta Drive, Suite 303, Whitehall, PA 18052  
Fax: 800-813-0727  
Email: [sschaffer@nchec.org](mailto:sschaffer@nchec.org)**

**Application Checklist**  
**(Do not submit with application)**

- \_\_\_\_\_ Mission Statement is included
- \_\_\_\_\_ List of recent continuing education programs or proof of designated provider status is included
- \_\_\_\_\_ Organizational chart is included
- \_\_\_\_\_ Assurances are checked and signed by an authorized leadership representative
- \_\_\_\_\_ A copy of the Certificate of Attendance/Completion is included
- \_\_\_\_\_ A copy of an evaluation form to assess achievement of learning objectives is included
- \_\_\_\_\_ Payment for the appropriate application fee is included
- \_\_\_\_\_ List of affiliates is provided (if applicable)

An incomplete application may delay approval or result in denial of designation.