THE MEDICAL PRACTITIONERS AND DENTISTS BOARD KENYA

CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMME

Application for Accreditation as CPD Provider

Notes and guidelines for completing this form

1. Programs must have significant intellectual and practical input content and must be related to the practice of medicine, should be of relevance and benefit to medical and or dental practitioners, or other health professionals or allied workers or designed specifically for registered institutions. They should be concerned principally with new developments in the medicine, clinical practice, professional skills and management and with the primary objective to increase the competence of health professionals. A program of continuing professional development or education should emphasize ethical as well as practical and professional aspects of clinical practice and or strategic health planning resulting in the improvement of the professional competence of the participants or be relevant to the practise of medicine.

2. CPD programs include in-house institutional continuing medical education programs; long-term regular courses such as diplomas, and master's degrees and any other courses as may from time to time be specified by the Board.

3. The proposed program as well as all relevant materials should be sent along with the application so as to allow for early assessment of content. Please provide details of one program, which may be either recently held course or one you are due to hold, as an example with this application form.

4. The Board will normally assign a person to monitor all the conduct, duration and content of the program.

5. Providers are expected to keep records of attendees and the number of credits/hours acquired in a prescribed form.

6. Detailed particulars of the program tutors/speakers/resource persons should be provided including relevant qualifications and experiences in the specific subjects, the necessary practical skills to present the program effectively.

7. The aims and intended learning outcomes and contents should be clearly demonstrated by the providers.

8. A minimum period of three months should be allowed to process the application for accreditation. Accreditation only applies to future courses being offered and approval of the application being granted prior to the program taking place.

9. All administrative arrangements, accommodation and support services should be stated in advance.

10. The application will not be processed until all the relevant information is received

1. Name of intended service provider .....

Full Address: .....

Physical location: .....

Contact name: .....

Tel Number *(Landline):*.....

Email address: .....

Tel Number *(Mobile)* .....

Fax number .....

Other details.....

2. Indicate nature accreditation sought

☐ External program

☐ In-house institutional program

☐ Both

3. Program title(s) .....

4. Proposed date(s) .....

5. What method(s) of presentation will be used?

Teaching/Speeches ☐ other please specify ☐

Group discussion ☐ Videos/Films ☐

Study groups, exercises, ☐

6. Will the program be assessed?

Yes ☐

No ☐

If yes, by what method?

Examinations ☐ Project Write - up ☐

Assignments to participants ☐ Multiple-choice questions ☐

Other_____

7. What evaluation systems will you use? (Please give details on a separate sheet, if necessary)

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8. How long will the program last? (Tuition time only excluding breaks**)**.....

9. To who is the program aimed?

- Medical practitioners only ☐
- Dental practitioners only ☐
- Medical and dental practitioners ☐
- Specialists please specify ☐
- Health professionals ☐
- Other professionals ☐
- Employees ☐
- Other _____

10. Maximum number of participants for the program .....

11. At what level is the program aimed?

- Introductory ☐
- Intermediate ☐
- Advanced ☐
- Update ☐

12. A list of the program aims and intended learning outcomes

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13. Details of trainer(s) [name, qualification, experience relevant to program facilitated]

Trainer(s) Name	**Qualification**	**Topic**	**Relevant experience to topic**
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.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

14. If the course is to be assessed, details of the assessor's names, qualifications and sample assessments must be submitted to MPDB immediately after conclusion of the training.

15. Please attach the following:

a) University only - definitive course document

b) A copy of the intended programme (giving start and end time, amount of time spent on each section/part)

c) Set of course materials including, as applicable, case studies, lecture notes, exercises, delegate handouts

d) If workshops i.e. active delegate participation, give details of how this will be organised, total number of participants per group

e) Sample course quality evaluation form

f) Calendar of events

g) Application fee Kshs.15,000/- [non-refundable]

16. Referees:
(Please provide names of two referees who are familiar with your organisation and who have attended one of your programs, preferably medical or dental practitioners or registered institutions but not course tutors/speakers).

(1) **Name** .....

Job title .....

Physical Address .....

P.O. Box .....Tel no .....

Email .....Fax No.....

(2) **Name** .....

Job title .....

Physical Address .....

P.O. Box ..... Tel no .....

E-mail ..... Fax No.....

DECLARATION: The provider declares that all information provided herein is correct and agrees to comply with the criteria and terms and conditions of authorisation

Name .....

Signature .....

Job title .....

Date .....

Please return the duly completed application together with a cheque of Kshs 15,000/- made payable to "Medical Practitioners and Dentists Board"

Post or deliver to:
The Medical Practitioners and Dentists Board
Woodlands Road
Off Lenana Road
P.O. Box 44839
00100-NAIROBI.

FOR OFFICIAL USE

Recommendation.....

Conditions.....

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.....(*signature*)
Chairman
Medical Practitioners and Dentists Board

Date .....

..... (*signature*)
Chairman
CPD Committee

Date .....