

## **INSTRUCTIONS FOR SUBMISSION OF AUDIT DOCUMENTATION**

1. Provide completed forms as necessary to document that at the time of application you met the discipline and professional practice experience requirements as identified in the *2010 Certification Examination for Diabetes Educators Handbook*. You are encouraged to contact the NCBDE national office at 847-228-9795 if you have any questions about the required documentation prior to submission.
2. Submit the materials for receipt by the audit deadline date using certified mail or a traceable courier service to: NCBDE, Attn: Audit Process, 330 East Algonquin Road, Suite 4, Arlington Heights, IL 60005. (Telephone: 847-228-9795). **Notes:** 1) A certified mail, certificate of mailing or other courier receipt will serve as proof that the materials were submitted in the event the materials are not received by the deadline; and 2) ensure that the materials are sent to the NCBDE national office, NOT the Applied Measurement Professionals office in Kansas.

**An audit submitted without all required information or incorrectly completed will be rejected.**

Any applicant who does not or cannot provide required information, or who does not meet eligibility requirements based on the documentation submitted, will be declared ineligible. Eligibility requirements are not waived nor are exceptions made.

## **CHECKLIST – AUDIT MATERIALS FOR INITIAL CERTIFICATION**

Use this checklist to ensure that you have completed all required procedures before submitting your audit documentation.

- Have you completed all required forms AND submitted sufficient documentation that you met all of the requirements at the time of application? (Documentation will require AT LEAST one Section B, one Section C and one Section D. The exact number of Section B and C forms required is dependent on the number of jobs needed to verify all practice requirements were met upon application.)
- Have you included a copy of your current license or verification letter of licensure or registration? If applying under a qualifying advanced degree, did you include an official transcript with the original paper application?
- Have you made copies of all audit materials for your files?
- Have you arranged to send all audit materials to NCBDE by certified mail or traceable courier service?

**Retain this checklist, a copy of your application/audit materials, and the proof of mailing for your records. Under no circumstances are materials, including copies, returned to applicants.**

Acknowledgement of receipt of your audit materials should be sent by NCBDE no later than 2 weeks after receipt of materials.

**SECTION A – Contact Information and Discipline Requirement Verification Form**

Complete BOTH sections.

**1) APPLICANT INFORMATION**

Name (print/type) \_\_\_\_\_

For identification purposes, provide the last 4 digits of your social security number or full date of birth (mm/dd/yyyy) as reported on your application: \_\_\_\_\_

Date on line application completed or paper application signed: \_\_\_\_\_  
(exact month, day and year)

Mailing Address: \_\_\_\_\_  
Street Address Apt/Unit

\_\_\_\_\_ City St Zip

Daytime phone (including area code): \_\_\_\_\_ Extension

Email address: \_\_\_\_\_

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

**2) DISCIPLINE VERIFICATION INFORMATION**

Check ONE only and include the original date of licensure/registration as required.

- I applied under the license/registration requirement: Enclosed is either a photocopy of current license, registration or certificate from the issuing credentialing body or an official written verification form from the appropriate credentialing body. If the current license or registration documentation does not currently verify that it will be current at the time of the last day of the Examination window applied for (June 30 for spring examination; December 31 for fall examination), proof of license or registration must also be submitted to NCBDE no later than two weeks prior to the first day of the Examination window.

**Identify the original date\* of licensure/registration:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

\*See below:

- a. For clinical exercise physiologists, clinical psychologists, registered nurses, nurse practitioners, clinical nurse specialists, occupational therapists, optometrists, pharmacists (RPh or PharmD), physical therapists, physicians, or podiatrists, indicate the month/day/year you first received your license/certificate to practice in your professional discipline, i.e., the date your license/certificate was originally conferred.
- b. For physician assistants or dietitians, indicate the month/day/year you were first registered, e.g., for a registered dietitian, report the day you originally received registration with the Commission on Dietetic Registration, NOT state license information. Physician assistants and dietitians should NOT report or submit state license information.

- I applied with a qualifying advanced degree. An official transcript was submitted with my original application. The transcript included information on the degree awarded, the date it was awarded, and the area of concentration.

**SECTION B – Professional Practice Experience**

Complete one Section B for each position required to document meeting 1) a minimum of 2 years of professional practice experience in the discipline under which you applied (e.g., applied as a RN – 2 years experience working as a registered nurse or applied as a RD – 2 years working as a registered dietitian); **AND** 2) 1000 hours of professional practice experience in diabetes self-management education (“DSME”) in no more than 4 years prior to the date of application **WITH** at least 40% of those hours (400 hours) accrued in the 12 months prior to the date of application.

Applicant’s Name: \_\_\_\_\_ **\*\*Job #** \_\_\_\_\_  
**\*\* (list jobs chronologically with #1 present job)**

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

Department: \_\_\_\_\_

Institution/Practice Site: \_\_\_\_\_

Street Address \_\_\_\_\_

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

1. **Employment status** (circle one ONLY):      Yes      No      I am currently employed/self-employed in this position.

2. **Dates of experience in this position:**  
**FROM** \_\_\_\_\_ **TO** \_\_\_\_\_ (Note: “TO” date can be no later than the date the on line application was submitted **OR** paper application signed)  
 (mm / dd / yyyy)                      (mm / dd / yyyy)

3. **For the dates identified above**, I am claiming a **total** of \_\_\_\_\_ hours of DSME practice experience in this position. (Note: Regardless of the dates of experience reported in 2. above, the hours reported cannot be counted if accrued more than 4 years before the date of application).

4. **For the 12 months prior to the date I applied for the Examination**, I am claiming a **total** of \_\_\_\_\_ hours of DSME practice experience in this position. (Note: For previous jobs, rather than a current job, the hours may need to be reported as zero – Do NOT leave the line blank.)

5. **Practice setting** (*check one only*):  
 Hospital Inpatient Only                       Physician’s Office                       Self-Employment/Private Practice  
 Hospital Outpatient Only                       Community Health Agency  
 Hospital Inpatient & Outpatient                       Home Health Agency  
 Other (specify) \_\_\_\_\_

6. **Provide a description of the setting.** Use a separate sheet of paper if necessary (include your name and the last four digits of your social security number).  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. **Delivery method for DSME you provide(d) in this job** (*check one only*):  
 Face to face only                       Electronic only (e.g., telephone, internet)                       Face to face and electronic

8. **For self-employment positions only, include referral information below:**  
 Applicants who are claiming self-employment experience must report sources of patient/client referrals, including names, addresses and telephone numbers, the length of time each has been a referral source, and number of patients/clients referred. Use a separate sheet if necessary. Health care professionals who may not have referral sources (e.g., physicians) must describe the process by which persons with diabetes come to their practices. **Complete information must be provided for each referral source.**

Name of Referral Source	Address and Telephone	Length of Time as Referral Source	Number of Patients/ Clients Referred
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**I do not have referral sources for my private practice.** Provide a separate sheet of paper describing the process by which persons with diabetes come to your practice (include your name and the last four digits of your social security number).

**SECTION C – Professional Practice Verification Form**

Provide one Section C for each Section B submitted. For employment positions, the immediate supervisor must complete Box 1. For self-employment positions, a department head, chief of staff, Certified Diabetes Educator® or other licensed health care professional who knows you and is familiar with your practice must complete Box 2.

Applicant's Name: \_\_\_\_\_ Job # \_\_\_\_\_

**Box 1 - For Employment Verification. This statement must be signed and dated.**

This applicant:

- 1) provides/d DSME as defined in the *2010 Certification Examination for Diabetes Educators Handbook*;
- 2) has provided correct information regarding dates of experience and hours of DSME being claimed on Section B for this job; and
- 3) if DSME is/was provided solely by electronic means, there is a provision for client referral to another health care professional when face-to-face education is/was indicated.

I have reviewed Section B for this position and attest that I am the applicant's supervisor and that to the best of my knowledge all information is accurate, complete and truthful. I understand I may be contacted regarding this information.

Supervisor's Name (printed) \_\_\_\_\_

(must be applicant's immediate supervisor or notation regarding reason qualified individual other than immediate supervisor completing form must be included with this document)

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

(Original Signature Only)

Title \_\_\_\_\_ Department \_\_\_\_\_

Institution \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Daytime Telephone \_\_\_\_\_

(include area code)

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

**Box 2 – For Self-Employment Verification. This statement must be signed and dated.**

- 1) I have known the applicant above since \_\_\_\_\_ (mm/yyyy) in my capacity as \_\_\_\_\_ (your professional title).
- 2) I am familiar with her/his practice as a diabetes educator.
- 3) I (circle one) → YES NO refer/referred individuals with diabetes to this practice.
- 4) The applicant a) provides/d DSME as defined in the *2010 Certification Examination for Diabetes Educators Handbook*; and b) if DSME is/was provided solely by electronic means, there is a provision for client referral to another health care professional when face-to-face education is/was indicated.
- 5) I am NOT the applicant, spouse, business partner or employee of the applicant.
- 6) I have reviewed Section B for this position and attest that to the best of my knowledge all information is accurate, complete and truthful. I understand I may be contacted regarding this information.

Name (printed) \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

(Original Signature Only)

Title \_\_\_\_\_ Department \_\_\_\_\_

Institution \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Daytime Telephone \_\_\_\_\_

(include area code)

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

**NCBDE Audit Documentation Initial Certification 2010**

**SECTION D – Continuing Education Activities Summary Form**

Submit one Section D. Application for initial certification requires that individuals document accrual of 15 clock hours of continuing education in content areas applicable to diabetes in the 2 years prior to the date of application. Refer to the Guidelines for Reporting Continuing Education Activities provided in the Audit Documentation packet before completing this form.

Applicant's Name: \_\_\_\_\_

Title of Activity	NCBDE Recognized Provider* (Do not use abbreviations or acronyms) *Provider must appear on the NCBDE List of Recognized Providers.	Date Attended or Completed	Hours Being Claimed**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
<b>TOTAL HOURS**</b>			
<b>** (must total at least 15 clock hours in no more than 2 years prior to the date of application)</b>			

## Guidelines for Reporting Continuing Education Activities

### Self-Assessment

It is expected that health care professionals specializing in diabetes self-management education will want to demonstrate that their knowledge and skills are up-to date and that they are able to practice proficiently and safely. It is hoped that all who participate in the initial/renewal of certification process will engage in a personal assessment to identify professional needs and participate in appropriate activities.

### Continuing education activities:

- must be approved by a provider on the NCBDE List of Recognized Providers.
- must be applicable to diabetes. All subject matter on the Certification Examination Content Outline published in the 2010 Certification Handbook for Diabetes Educators is considered applicable to diabetes.
- must be completed as defined by the renewal of continuing education cycles policy. (All continuing education activities must be completed prior to the application deadline and before submitting the application.)
- must be at a professional level that enhances the quality and effectiveness of diabetes self-management education practice.
- does not have to be discipline specific nor does it have to be in any specific area of concentration, e.g., social workers may attend a diabetes related nursing program and use those clock hours for renewal of certification.

### Activities acceptable for continuing education

- Continuing education courses
- Independent study
- Seminars
- Online programs
- Workshops
- Telephonic or video conference programs
- Conferences

### Activities not acceptable for continuing education

- Academic courses
- Other certification/credentials awarded
- Elected office or serving on Boards and/or Committees
- Articles or books written by the applicant
- Journal clubs or professional reading
- Presentations or lectures by the applicant
- Posters or poster sessions and exhibits
- Preceptorships or mentor hours
- Research
- Volunteer activities

### Continuing Education Hour

A. All continuing education activities must be reported in clock hours, i.e., the actual time spent on the continuing education activity, not contact hours, credits, or units awarded by the recognized provider. One clock hour equals 60 minutes.

In many professions, a 60-minute hour is equivalent to 1 contact hour, i.e., 60 minutes equals 1 contact hour. In nursing prior to 2007, however, a 50-minute hour was equivalent to one contact hour, i.e., 50 minutes equaled 1 contact hour. To provide a common measure for continuing education activities, NCBDE requires that activities be reported in clock hours. If a recognized provider awarded 2 contact hours for a continuing education activity that was two hours in length, 2 clock hours would be reported to NCBDE for that activity. For that

same two-hour program prior to 2007, if the provider awarded 2.4 contact hours for nurses on the basis of a 50 minute hour, it would be necessary to convert those contact hours to clock hours. This would be done by multiplying 2.4 contact hours by 50 minutes, which is 120 minutes or 2 hours.

B. Presentations – Participants may include in the time to be counted as clock hours the course overview, introductions, the educational presentation, and questions and answers. Time may not be counted for general announcements, breaks, lunch, exhibits, or poster sessions.

C. Self study programs (online or written booklets) –Participants may count the actual time spent on completing the activity. Clock hours submitted cannot be more than the number of contact hours/credits/units awarded by the recognized provider.

### Recognized Continuing Education Providers

**Continuing education programs must be provided by or approved by one of the following:**

American Association of Diabetes Educators (AADE)  
 American Diabetes Association (ADA)  
 American Dietetic Association (ADA)  
 Accreditation Council for Pharmacy Education (ACPE)  
 Accredited or Approved Providers  
 Accreditation Council for Continuing Medical Education (ACCME-AMA) Accredited or Approved Providers  
 American Nurses Credentialing Center (ANCC) Accredited or Approved Providers  
 American Academy of Family Physicians (AAFP)  
 American Academy of Nurse Practitioners (AANP)  
 American Academy of Optometry (AAO)  
 American Academy of Physician Assistants (AAPA)  
 American Association of Clinical Endocrinologists (AACE)  
 American College of Endocrinology (ACE)  
 American College of Sports Medicine (ACSM)  
 American Medical Association (AMA)  
 American Nurses Association (ANA)  
 American Occupational Therapy Association (AOTA)  
 American Osteopathic Association (AOA)  
 American Physical Therapy Association (APTA)  
 American Psychological Association (APA)  
 American Podiatric Medical Association (APMA)  
 Commission on Dietetic Registration (CDR) Accredited or Approved Providers  
 Council on Continuing Medical Education (CCME-AOA) Approved Sponsors  
 Council on Podiatric Medical Education (CPME-APMA) Approved Sponsors  
 International Diabetes Federation (IDF)  
 National Association of Clinical Nurse Specialists (NACNS)  
 National Association of Social Workers (NASW)

Continuing education from accredited academic institutions within the United States or its territories granting degrees related to professional practice are also accepted.