**APPLICATION FORM - PLEASE TYPE IF POSSIBLE.**

|  |
| --- |
| Complete and send to: Optometrists & Dispensing Opticians Board  Optometrists CPD Accreditation PROGRAMME  c/- NZAO, P O Box 51008,Tawa, Wellington 5249, NZ  Email address: [cpd@nzao.co.nz](mailto:cpd@nzao.co.nz) |

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***Details of Provider (person, institution or organization providing CPD activity)***

***Name:***

***Postal Address:***

***Email:***

***Phone: Fax:***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Details of Activity (CPD event or course)***

***Title:***

***Contact for Registration Enquiries (if different from above):***

***Postal Address:***

***Email:***

***Phone: Fax:***

# Will this be a single event (one-off), or repeated (i.e. same activity at a later date and/or another venue)?

# One-off Repeat N/A

# Venue(s)

# Date(s)

**Is this activity available to all optometrists/dispensing opticians? Yes No**

**If no, please provide a brief explanation:**

**Is this activity available via the internet? Yes No**

**Is this activity a teleconference? Yes No**

**Will this activity be recorded (audio or video)? Yes No**

**Number or CPD points applied for: CD POINTS GEN POINTS**

**(Subject to assessment and approval by CPD committee)**

**Total number of hours to be accredited: Hours**

# SUMMARY OF CE CONTENT

**Event Title:**

**Presenter(s):**

**Format:** Lecture Workshop Conference Other (please specify)

**Duration:**

**Case Summaries**

***For CPD Credits to be added to the account of any individual optometrist the Board CPD recorder (NZAO) needs both:***

1. *The signed list of attendees from you as organiser(Appendix 1)*
2. *An individual attendance form to be submitted by each optometrist on the list.*

In addition, presenters can also get extra points if they submit the “Peer review Activity Form”(Appendix2)

*Appendix 1*

**Record of Attendance: Glaucoma Peer Review Activity – Optometrists**

***(To be completed by the activity organiser and submitted to the NZAO for recording of Glaucoma CPD credits)***

*Event Name: CPD Ref #*

*Date of meeting: Location of meeting:*

*Duration of meeting: Form completed by:*

*Ophthalmologist or Board-Approved Optometrist Glaucoma Prescriber*

*(if applicable):*

***To be completed by all attendees wishing to obtain Glaucoma CPD credits for attendance:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Attendee name** | **Board Registration number** | **Presented Case?**  **(incl patient ID for reference if audited)** | **Signature** | **Tick if TPA endorsed** |
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*Appendix 2*

**Glaucoma Peer Review Activity Form – Optometrists**

Name: Registration Number:

Date of meeting: Duration of meeting: CPD Ref #

*Required information (use a separate piece of paper for additional information if necessary)*

*Ongoing CPD requirements require participation in peer review sessions specifically on glaucoma management. This will include presenting at twice yearly two hour structured peer review sessions specifically on glaucoma management. These sessions must be run in accordance with the Board policy on continuing professional development and an ophthalmologist must be present. When it is not possible to have an ophthalmologist attend, the Board may approve, at its discretion, an optometrist glaucoma prescriber*.

|  |
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| *Case presentation (describe why you chose to present the case, and what clinical information you provided in presenting it)* |

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| --- |
| *Case discussion (summarise the questions and issues raised by peers, and the outcome of the discussion)* |

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| *Reflection to be completed after presentation (for example, was there general agreement that your diagnosis and management was appropriate? If not, how would you approach a similar presentation in the future? Are you intending to make changes to your practice or undertake education in a particular area of as a result of presenting this case?)* |

By signing below, I confirm that the information provided in this form is true and correct.

*Signed: Date:*

By signing below, I confirm that presented a glaucoma case at this meeting, as described above.

*Signed: Name:*

*(Ophthalmologist or Board-Approved Optometrist Glaucoma Prescriber)\**

\* A Board approved optometrist glaucoma prescriber is someone who has been approved by the Board for glaucoma management and prescribing and has also been specifically approved to supervise others in their pursuit to become approved for glaucoma management and prescribing.

**INDIVIDUAL OPTOMETRIST’S RECORD OF ATTENDANCE AT CPD**

To be completed by each optometrist attending a CPD event. To claim CPD credit for the event, optometrists should mail this form to: Optometrists CPD Accreditation Committee of the Optometrists & Dispensing Opticians Board,

C/- NZAO CPD Recording Programme, P O Box 51008, Tawa, Wellington 5249, NZ;

Email:[cpd@nzao.co.nz](mailto:cpd@nzao.co.nz)

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| **Event Name:** |  | | | |
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| **Event Organiser:** |  | | | |
|  |  | | | |
| **Event CPD Reference Number:** | |  | **Event Date:** |  |

**If you did not attend any of these sessions, Please cross the line out.**

Sessions within the Event:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Start Time – End Time** | **Session Name** | **Presenter(s)** | **Hours attended** | **Credits Office Use Only** |
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| Total Hours |  |  |
|  | | Total Credits |

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| OPTOMETRIST’S NAME: | NZAO Number (if applicable): | Board Registration Number: |

|  |  |
| --- | --- |
| Email Address: |  |

|  |  |
| --- | --- |
| SIGNED: …………………………………………………… | DATE: ………………………….. |