Tel: (345) 949-2813/ 946-2084

Email: HPBUSERS@gov.ky
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Government Administration Building,
Box 132, 133 Elgin Avenue,
Grand Cayman KY1-9000
CAYMAN ISLANDS

CAYMAN ISLANDS NURSING AND MIDWIFERY COUNCIL
CONTINUING NURSING EDUCATION (CNE) SUMMARY FORM

Name: _____ Registration Number: _____

CNEs must be completed within the two (2) year period prior to submission of application

N.B. One (1) contact hour is equivalent to 60 minutes
120 hours of preceptorship = 10 continuing education units.
60 hours of preceptorship = 5 continuing education units

Current ACLS/ BLS/ CPR/ NALS/ NRP/ PALS *(do NOT include in CNEs overleaf)*

Expiry Date: _____ Provider: _____

Please select ONE of A, B *or* C (reflecting your highest qualification)**:**

☐ **A**	***Advanced Practice Nurse:*** ☐ Clinical Nurse Specialist ☐ Registered Midwife ☐ Nurse Anaesthetist ☐ Nurse Practitioner ☐ Public Health Nurse Area of Specialty: _____ ***40 hours required*** *(includes mandatory, 28 related to your advanced practice area and the additional in general practice)*
☐ **B**	***Post-basic Qualification*** (e.g. Mental Health/ OR/ etc.): _____ ***35 hours required*** *(includes mandatory, 25 related to your post-basic qualification area and the additional in general practice)*
☐ **C**	***Registered Nurse*** ☐ Registered General Nurse ☐ Registered Nurse ☐ Registered Nursing Assistants Practice Area: _____ ***25 hours required*** *(includes mandatory, 20 related to your practice area and the additional in general practice)*

Please list all CNEs on summary table overleaf

Mandatory CNEs (1 hour each): Disaster Preparedness, Prevention of Blood and Body Fluid Exposure, Prevention of Medication Errors

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Name: _____ Registration Number: _____

Primary Area of Practice _____

Title of Program	Sponsor/ Provider	Type of CNE	Date D/M/Y	Contact Hours
MANDATORY CNEs				
Disaster Preparedness (1 hour)				
Prevention of Blood and Body Fluid Exposure (1 hour)				
Prevention of Medication Errors (1 hour)				
			Total	

Title of Program	Sponsor/ Provider	Type of CNE	Date D/M/Y	Contact Hours
AREA OF PRACTICE/SPECIALTY CNEs				

			Total	

Title of Program	**Sponsor/ Provider**	**Type of CNE**	**Date D/M/Y**	**Contact Hours**
GENERAL CNEs				

			Total	

CUMULATIVE OF TOTAL CNE'S SUBMITTED _____

I certify that the above statement is a true and accurate record of the continuing education programs I have completed.

Signature: _____ Date: _____