



PROGRAM DESCRIPTION FORM

DIRECTIONS: A completed copy of this form is to be submitted to the ACPE office at least 30 days prior to the scheduled date for each continuing education program that you offer as an ACPE - Approved Provider

UNIVERSAL PROGRAM # _____ - _____ - _____ - _____ - _____

NEW SUBMISSION:

A PDF HAS PREVIOUSLY BEEN SUBMITTED FOR THIS PROGRAM **ONGOING PROGRAM PLEASE NOTE ADDITIONAL DATES AND LOCATIONS**
 PLEASE NOTE THE BELOW MARKED CHANGES IN INFORMATION

PROVIDER NAME: _____

COSPONSOR(S): _____

PROGRAM TITLE: _____

LEARNING OBJECTIVES: _____

WOULD YOU LIKE THIS PROGRAM LISTED IN THE PHARMACIST LEARNING ASSISTANCE NETWORK (PLAN) DIRECTORY?

YES NO

CONTACT HOURS: _____

CEUs: _____

LIVE FORMAT:

TELECONFERENCE
 SEMINAR
 INTERNET

HOME STUDY FORMAT:

INTERNET
 JOURNAL ARTICLE
 MONOGRAPH
 VIDEO CASSETTE
 AUDIO CASSETTE
 COMPUTER ASSISTED
 OTHER _____

ONGOING PROGRAMS:

INITIAL RELEASE DATE: _____
DATE OF LAST REVIEW OR REVISION: _____
PLANNED
EXPIRATION DATE: _____

PLEASE RETURN COMPLETED FORM TO:
American Council on Pharmaceutical Education
311 West Superior Street, Suite 512
Chicago, Illinois 60610
Phone (312) 664-3575 Fax (312) 664-7008

LIVE AND TELECONFERENCE PROGRAMS:

DATE(S): _____ CITY: _____ STATE: _____

SUBMITTED BY

SIGNATURE _____ DATE _____

NAME (Type or Print) _____ PHONE _____