Application Date:_____
County:_____

APPLICATION FOR INITIAL 4-YEAR STATE CERTIFICATION OF OUTPATIENT DIABETES SELF-MANAGEMENT EDUCATION/SUPPORT (DSMES) PROGRAM WITH ADA RECOGNITION OR ADCES ACCREDITATION

Iowa Administrative Code 641-9, Outpatient Diabetes Education Programs

1. Name of Program: _____

2. Name of Facility: _____
   Address: _____
   City: _____ Zip: _____ County: _____
   Telephone: _____ FAX: _____
   ☐ Hospital Based ☐ Physician Office/Clinic
   ☐ Public Health Agency ☐ Pharmacy
   ☐ Other: _____

3. Program Physician: _____
   Address: _____
   Telephone: _____

4. Program Coordinator: _____
   Address: _____
   Telephone: _____
   E-mail address: _____ FAX_____

5. Advisory Committee members:
   Physician (required): _____
   Registered Nurse (required): _____
   Licensed Dietitian (required): _____
   Pharmacist (required): _____
   Other (_____): _____
   Other (_____): _____
   Other: (community member/person with diabetes recommended:_____

6. Primary Instructor(s) _____
   _____

7. Supporting Instructor(s) _____
   _____

8. ☐ ADA Recognized or ☐ ADCES Accredited
   Recognized/Accredited from (date) _____ to (date) _____

Return to: Hanna de Geest, MPH – Self-Management Coordinator
Iowa Department of Health and Human Services
Email: hanna.degeest@hhs.iowa.gov

Application Date:_____
County:_____

	GUIDANCE FOR APPLICATION FOR CERTIFICATION AS A STATE CERTIFIED OUTPATIENT DIABETES EDUCATION PROGRAM
641-9.4(135) Application procedures for American Diabetes Association-recognized and Association of Diabetes Care and Education Specialists-accredited programs. *(formerly American Association of Diabetes Educators)*	**641—9.4(135) Application procedures for American Diabetes Association (ADA)-recognized and Association of Diabetes Care and Education Specialists (ADCES)-accredited programs** (*formerly American Association of Diabetes Educators (AADE).* When a program is recognized by the American Diabetes Association or accredited by the Association of Diabetes Care and Education Specialists, the program shall apply for certification by submitting the following to the department: **9.4(1)** A copy of the Certificate of Recognition provided by ADA or the Certificate of Accreditation provided by ADCES. **9.4(2)** The name, address and telephone number for the program. **9.4(3)** The names of the program coordinator, program physician, primary and supporting instructors, and advisory committee members. **9.4(4)** Copies of current licenses for all Iowa-licensed professionals named in 9.4(3). **9.4(5)** The name and a copy of both the Iowa licenses and continuing education hours of any pharmacist who serves as program staff. A pharmacist shall be a primary or supporting instructor or advisory committee member and shall meet the education requirements in 9.8(6), 9.8(7) or 9.8(8).
641-9.10(135) Annual report.	**641-9.10(135) Annual report.** Summary data shall be completed annually by each program and sent to the department (when requested). The data shall include but not be limited to the number of times the program was presented, the number of outpatients that participated, and a summarized description of program participants including type of diabetes, age, race and sex.

Application Date:_____
County:_____

INITIAL CERTIFICATION CONTINUING EDUCATION DOCUMENTATION

(When ADA recognized/ADCES accredited, needed for Pharmacists only.)

Pharmacist Name _____ License/Registration Number _____

☐ Primary Instructor (Initial - 32 hours)

☐ Supporting Instructor (Initial - 16 hours)

☐ Professional Advisory Board Member (Initial - 8 hours)

Continuing Education: (Education within past four years – add additional pages as needed)

Date of Meeting	Location	Name of Course	Course Sponsor	Hours
				Total Hrs.____