

# Kansas State Board of Nursing Continuing Education Annual Report

Reporting Year:

Name of Provider	
LT Provider Number:	
Legal Body (if different from name of Provider)	
Address of Provider	
Program Coordinator	
Phone Number	
E-mail address	

## Interactive Offerings

Total Number of Offerings		
Total Number of Offering Contact Hours: <small>Sum of all contact hours presented</small>		
Total Number of Participants	RN	
	LPN	
	LMHT	
Offering Contact Hours taught by: <small>Sum of CH taught by each category; total should be the same as "Total Number of Offering Contact Hours"</small>	Nurses	
	Others	

## Independent Study Offerings

Complete only if you offer Independent Study

Number of Independent Study topics offered:		
Total Number of Independent Study Contact Hours offered: <small>Sum of all contact hours for IS topics</small>		
Total Number of Participants	RN	
	LPN	
	LMHT	

I declare under penalty of perjury under the laws of the State of Kansas that the information provided is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Providership Coordinator

\_\_\_\_\_  
Date