

DVD viewer:

Enclosed please find the DVD for the **monthly UPDON videoconference**. Below find the instructions for processing the materials and returning to our office. **You have 1 week from receipt of the materials to view the DVD and return to our office.** Please contact us if you need more time. Thank you.

INSTRUCTIONS:

1. Handouts are available at www.diabetesinmichigan.org. Click on the UP, then click on videoteleconference handouts (left side of page). Handouts include:
 - Attendance Sheet
 - Attestation Form**
 - Evaluation Form
 - Presentation Outline
 - Handouts for Presentation
2. View DVD.
3. Complete the sign-in attendance sheet, attestation form and evaluation form.
4. Mail **original** completed attendance sheet, attestation form, evaluation form and the DVD to:

**Paula Ackerman, MS, RD, CDE
UPDON
220 W Washington, Ste 340
Marquette, MI 49855**

5. **Upon receipt of the sign in, evaluation and attestation form, we will mail or email a certificate of completion to you.**

Should you have any questions regarding the continuing education program or this process, call me with any questions (906) 228-9203 or (800) 369-9522 or email me at yooperfive@hotmail.com.

*****Please note UPDON's new mailing address.*****

**Michigan Department of Community Health
Michigan Diabetes Outreach Network
Nursing Management of Diabetes 2007-2009**

ED 1 Taped Presentation Attestation Form

TITLE OF ED 1 TAPED PRESENTATION:

Print

Participant Name:

Print

Signature

Date:

Signing this form attests to you viewing the complete tape of the ED 1 of the ED 1 presentation listed above. Upon completion of viewing the Taped ED 1 presentation the completed attestation form must be returned to the DON office with your registration/evaluation forms and post-test for you to receive your certificate for 1.0 contact hours.

This educational activity has been approved by the MNA, which is accredited to approve continuing education in nursing by the American Nurses Credentialing Center Commission on Accreditation for 1.0 contact hours.

Certificate # / Title of Educational Activity:

Contact Hours: 1.0 (RNs)

Name of Location/Hospital/University:

Presenter:

Complete Address (Street, City, State, & Zip):

Date:

NOTE: Drivers License or Professional Number is Required for Awarding Contact Hours

ATTENDANCE LIST

Name: (print legibly)
Professional or Drivers license #:
Address:
City, State, Zip:
Email:
Phone:
Profession: RN LPN RD Other (specify)
Agency Affiliation:
Name: (print legibly)
Professional or Drivers license #:
Address:
City, State, Zip:
Email:
Phone:
Profession: RN LPN RD Other (specify)
Agency Affiliation:
Name: (print legibly)
Professional or Drivers license #:
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City, State, Zip:
Email:
Phone:
Profession: RN LPN RD Other (specify)
Agency Affiliation:

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Agency Affiliation:
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Professional or Drivers license #:
Address:
City, State, Zip:
Email:
Phone:
Profession: RN LPN RD Other (specify)
Agency Affiliation:
Name: (print legibly)
Professional or Drivers license #:
Address:
City, State, Zip:
Email:
Phone:
Profession: RN LPN RD Other (specify)
Agency Affiliation: