

QAP Annual Record

Reporting Year: _____

Continuing Education and Professional Development

Activity 1

Learning Need	
Description of Activity	
Date:	Duration:
Location:	

Activity 2

Learning Need	
Description of Activity	
Date:	Duration:
Location:	

Activity 3

Learning Need	
Description of Activity	
Date:	Duration:
Location:	

Peer Case Reviews

Date	Duration	Number of Cases Reviewed	Names of participating midwifery practice groups or health care institutions

Quality of Care Evaluation

I have taken action on feedback received in my Quality of Care Evaluations <input type="checkbox"/>

Declaration

I, _____, declare that I have met the following required components of the Quality Assurance Program in accordance with the General Regulation and College policies and guidelines for the period October 1, 2018 – September 30, 2019:

Continuing education and professional development

Peer case reviews

Quality of care evaluations

I acknowledge and understand that:

I have records of my participation in the above continuing education and professional development activities, peer case reviews and completed quality of care evaluations (and the actions I have taken) as required by the General Regulation O. Reg 335/12 and College policies and guidelines.

I must retain a copy of my QAP records for 5 years.

It is professional misconduct to fail to co-operate with the Quality Assurance Committee.

It is professional misconduct to fail to take reasonable steps to ensure that any information provided by or on behalf of me to the College is accurate.

Signature: _____ Registration Number _____ Date _____