APPLICATION FOR NEW COURSE

1. Submitted by College of Nursing ____________________________ Date 9/25/07

   Department/Division offering course Undergraduate Nursing Program ____________________________

2. Proposed designation and Bulletin description of this course

   a. Prefix and Number NUR 875
   b. Title* Nur Care of Childbearing Families
   *NOTE: If the title is longer than 24 characters (including spaces), write
   A sensible title (not exceeding 24 characters) for use on transcripts ____________________________

   c. Lecture/Discussion hours per week 2
   d. Laboratory hours per week 6

   e. Studio hours per week ________________
   f. Credits 4

   g. Course description

   This course is designed to provide classroom and clinical experiences to enable the student to provide continuity of
   nursing care for families during uncomplicated labor and delivery, postpartum and neonatal periods. Lecture 2 credits:
   clinical 2 credits (6 hrs per week).

   ____________________________

   h. Pre-requisite NUR 871, BCLS Certification, required immunizations, or consent of instructor.

   Co-req. NUR 873.

   i. May be repeated to a maximum of ________________ (if applicable)

   ____________________________

4. To be cross-listed as

   Prefix and Number ____________________________

   Signature, Chairman, cross-listing department ____________________________

5. Effective Date Fall 2008 (semester and year)

6. Course to be offered ☒ Fall ☐ Spring ☐ Summer

7. Will the course be offered each year? ☒ Yes ☐ No
   (Explain if not annually)

   ____________________________

8. Why is this course needed?

   The current course NUR 873 (7 credits) does not provide sufficient time to cover the significant content areas in the Nursing Care of
   Childbearing Families (Obstetrics) and Childbearing Families (Pediatrics). Students consistently report in course evaluations, confusion in the
   two content areas when OB and Peds share lecture days. With the doubling of the nursing enrollment from 40 to 80 students each semester, it
   is increasingly more difficult to schedule OB and Peds clinical experiences when part of the same course.
9. a. By whom will the course be taught? Regular Faculty

b. Are facilities for teaching the course now available? Yes ☒ No ☐
If not, what plans have been made for providing them?

10. What enrollment may be reasonably anticipated? 80

11. Will this course serve students in the Department primarily? Yes ☒ No ☐
Will it be of service to a significant number of students outside the Department? Yes ☐ No ☒
If so, explain.

Will the course serve as a University Studies Program course? Yes ☐ No ☒
If yes, under what Area?

12. Check the category most applicable to this course
   ☒ traditional; offered in corresponding departments elsewhere;
   ☐ relatively new, now being widely established
   ☐ not yet to be found in many (or any) other universities

13. Is this course applicable to the requirements for at least one degree or certificate at the University of Kentucky? Yes ☒ No ☐

14. Is this course part of a proposed new program? Yes ☐ No ☒
If yes, which?

15. Will adding this course change the degree requirements in one or more programs? Yes ☒ No ☐
   If yes, explain the change(s) below (NOTE – If “yes,” a program change form must also be submitted.)
   This course is an additional requirement for the BSN Degree.

16. Attach a list of the major teaching objectives of the proposed course and outline and/or reference list to be used.

18. If the course is 400G or 500 level, include syllabi or course statement showing differentiation for undergraduate and graduate students in assignments, grading criteria, and grading scales. ☐ Check here if 400G-500.

19. Within the Department, who should be contacted for further information about the proposed course?
   Name: Dr. Patricia V. Burkhart, Director
   Undergraduate Program
   Phone Extension: 323-6253
APPLICATION FOR NEW COURSE

Signatures of Approval:

______________________________________________________
Date of Approval by Department Faculty

______________________________________________________
Date of Approval by College Faculty

______________________________________________________
*Date of Approval by Undergraduate Council

______________________________________________________
*Date of Approval by Graduate Council

______________________________________________________
*Date of Approval by Health Care Colleges Council (HCCC)

______________________________________________________
*Date of Approval by Senate Council

______________________________________________________
*Date of Approval by University Senate

*If applicable, as provided by the Rules of the University Senate

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