**Requestor Information:**

CME Activity Director  
(Name and Title)  
Organization:  
Organization:  
Department:  
Address:  
Phone:  Fax:  E-mail:  

Departmental Contact person

Name:  
Phone:  Fax:  E-mail:  

**Activity Information**

Activity Title:  

Type of CME Activity:
- RSC - Grand Rounds, M&M, Tumor Board  
- Other  
- Annual Conference/Symposium  
- Journal CME  
- Internet CME  
- Enduring Material

Location of proposed activity:  

Date(s) of proposed activity:  Beginning date:  Ending date:  

Time activity begins:  Time activity ends:  

How often will the CME activity be held?  Daily  weekly  monthly  other  

This activity will be held on:  Monday  Tuesday  Wednesday  Thursday  
- Friday  Saturday  Sunday

How many sessions will be offered?  Total number of credits requested:  

**The following information is required in accordance with ACCME Essentials and the OCME policies for planning a CME activity.**

1. Describe process used to plan this activity and attach minutes of planning committee meetings.

2. Target audience - Indicate the proposed target audience (list specialties) and any special background requirements of the prospective participants:
3. List the methods used to identify the need for this educational activity. Check all that apply and ATTACH supporting documentation:

   Expert Needs:
   - Expert Faculty (activity faculty, planning committee members, departmental chair) – please list:
   - Peer-reviewed Literature (please provide summary)
   - Research Findings:
   - Required by a Medical School Authority:
   - Required by Governmental Authority/Regulation/Law:

   Participant Needs:
   - Needs Assessment Survey of Target Audience (please provide summary)
   - Focus Panel Discussions/Interviews (please provide summary)
   - Previous Related Evaluation Summary (please provide summary)
   - Requested by affiliated institutions or physician groups:
   - Requests from physicians:

   Observed Needs:
   - Adverse drug events:
   - Database analyses (e.g., RX changes, diagnosis trends, etc.):
   - Epidemiological data:
   - Hospital/clinic QA analyses:
   - P&T or QI data/guidelines:
   - Mortality/morbidity data:
   - National clinical guidelines (NIH, NCI, AHRQ, etc):
   - Other clinical observances (specify):
   - Referral diagnosis data:
   - Specialty society guidelines (specify):

   Environment:
   - American Board of Medical Specialties (ABMS)/Accreditation Council for Graduate Medical Education (ACGME) Competencies:
     - Interpersonal and Communication Skills
     - Medical Knowledge
     - Professionalism
     - Practice-based Learning and Improvement
     - Systems-based Practice
     - Patient Care
   - Healthy People 2010 Objectives:
   - The Joint Commission Standards/Core Measures:
   - Laws/Regulations:
   - Public Health Organizations (specify):
   - Other societal trends (specify):

4. Based on number 3, what were the needs determined to be?

5. Educational Objectives: List at least 3 expected learning outcomes in terms of knowledge, skills, attitudes and professional practice. At the conclusion of this activity, the participant should be able to:

   1.
   2.
   3.

6. Educational methods: Based on the objectives of the activity, indicate the proposed methods(s) of instruction:

   - lecture
   - case presentations
   - panel discussion
   - workshop
   - small group discussion

   - audio/video conference
   - other ______
7. Desired Results – Based on the need/gap the activity is addressing, what are the desired results of the activity? Said differently, “What is the activity designed to change?”

8. Will you be using brochure and other promotional materials?  ☐ Yes  ☐ No
   Please provide a draft of the proposed brochure with your CRF so that it can be approved prior to printing.

9. What kind of evaluation form will be used for this activity (CME credit will not be approved without an evaluation process)?

   ☐ Standard form (furnished by OCME)  ☐ other (must be approved by OCME)

10. Budget – Will a registration fee be charged?  ☐ No  ☐ Yes If yes, how much? ______

11. To whom will the check be made payable? ______

12. Commercial support: Please indicate if this activity will receive financial support from any commercial companies or vendors.  ☐ Yes  ☐ No

CME disclosure, budget and commercial support forms can be downloaded from our website – www.downstate.edu/cme

Signature: Activity Director ____________________________  Date: ____________________

Be sure to include the following with your CRF:

☐ Application Fee (RSC$150, $350 joint) (Annual conferences $1500, other- please call)
☐ A completed and signed CRF
☐ Signed Letter of Agreement
☐ Planning minutes
☐ Written statement of objectives
☐ Written statement of need, and NEEDS DATA
☐ A draft of your brochure or/and flyer
   (Must have date of activity, topics, lecturer, objective of the topic, accreditation statement and disclaimer)
☐ Preliminary Budget Plan
☐ Evaluation Form
☐ CME Disclosure Form (s)
☐ Commercial Support Form (s)

Return the completed CRF and Make checks payable to SUNY OCME

The Office of Continuing Medical Education
SUNY Downstate Medical Center
450 Clarkson Avenue, Box 1244
Brooklyn, NY 11203
Tel.: (718) 270-2422  Fax: (718) 270-4563
www.downstate.edu/ocme
E-mail ocme@downstate.edu

FOR OCME USE ONLY:
☐ Approved for AMA/PRA Category 1  ☐ Disapproved     Justification: ______

Coordinator ______