SUNY Downstate Medical Center | Office of Continuing Medical Education

CME CERTIFICATION REQUEST FORM (CRF)

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 <u>ATTACH</u> supporting documentation:**

<u>Expert Needs:</u>

☐ 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: _____

<u>Participant Needs:</u>

☐ 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: _____

<u>Observed Needs:</u>

☐ 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): _____

<u>Environment:</u>

☐ 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 _____