SUNY Downstate Medical Center | Office of Continuing Medical Education

Print Form Submit Form

CME Application Form

2011-2013

NOTE: REMEMBER TO INTEGRATE THE FOLLOWING INTO THE PLANNING PROCESSES AT EVERY STEP:

- All steps should be taken independently of commercial interest.
- Everyone (planner, presenter, dept. Chair, resident, fellow, etc.) who is in a position to control content must disclose all relevant financial relationships with a commercial interest to the provider.
- Disclosure must be made to the learners of relevant financial relationships and any commercial support for the CME activity
- The activity promotes improvements or quality in healthcare and not proprietary interests of a commercial supporter (Source: ACCME 07)

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

Departmental Contact person

Name:		
Phone:	**Fax**:	**E-mail**:

Section One: Logistics	
Activity Title:	
Type of CME Activity: ☐ RSS - 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**:

Section Two: Educational Planning

Professional Practice Gap: "a gap between what the professional is doing or accomplishing compared to what is "achievable on the basis of current professional knowledge."

1. Who are the physician target audience for the CME activity?

2. What are the professional practice gaps/educational needs of target audience that will be addressed?

3. Is it a gap in physician knowledge, competence, or performance?

4. How were those practice gaps identified? 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 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)
- ☐ 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): see attach
- ☐ Other clinical observances (specify): _____

Environment:

- ☐ American Board of Medical Specialties (ABMS)/Accreditation Council for Graduate Medical Education (ACGME) Competencies:
- ☐ Healthy People 2020 Objectives: _____
- ☐ The Joint Commission Standards/Core Measures: _____
- ☐ Laws/Regulations: _____
- ☐ Public Health Organizations (specify): _____
- ☐ Other societal trends (specify): _____

5. Based on the need/gap the activity is addressing, what is the activity designed to change?

☐ Competence ☐ Performance ☐ Patient Outcomes

6. Any identified barriers that may get in the way of changes in physician practice or patient care that will be addressed.

- ☐ Lack of time
- ☐ Budget/cost
- ☐ Reimbursement/ Insurance issues
- ☐ Other
- ☐ Lack of administrative support or resources
- ☐ Patient compliance issues
- ☐ Professional guidelines

7. What reminders/feedback related to the activity will be distribute to learners when they return to practice?

- ☐ Reminders via E-mail/newsletter
- ☐ social networks among learners
- ☐ Web Site to guidelines
- ☐ Interactive web-based tools
- ☐ Handouts- pocket cards, check list,etc
- ☐ Other

8. What were the QA or PI initiatives associated with this activity? *(For example,* heart failure (HF) as a focus area for quality improvement. The Medical Center has identified the HF core measures as an area for improvement. The Department has collaborated with the Quality Assurance (QA) or Performance Improvement (PI) department to provide CME sessions that will serve to both improve compliance with the HF core measures and provide a valuable learning opportunity for our physicians).

9. Based on the desired results of the activity, list 3 to 5 overall learning objectives for this CME activity.

10. What ACGME, ABMS or IOM related competency is associated with this activity?

☐ Patient Care ☐ Medical/Clinical Knowledge ☐ Communication Skills

☐ Professionalism ☐ System-based practice ☐ Practice-based learning & improvement

11. The educational format (s) that best support the objectives of the activity is/are:

☐ Listening to expert faculty
☐ Interacting with faculty using Q&A or open discussions
☐ Hands-on skills workshop
☐ Small group discussion
☐ Simulation with real/or simulated patients
☐ Reading materials such as journals with open discussions or Q&A
☐ Other

12. How do you plan to evaluate the activity to determine its effectiveness at meeting the needs and creating change in competence, performance, or patient outcomes? (Evaluation of learners' change in competence, performance or patient outcomes is required).

☐ Standard paper evaluation ☐ Post-course follow-up ☐ Survey ☐ Post-test ☐ Focus group
☐ Practice data ☐ other _____

13. Describe process used to plan this activity and ATTACH minutes of planning committee meetings and disclosure forms for all members in attendance.

14. Will you be using a brochure and other promotional materials? ☐ Yes ☐ No

Please provide a draft of the proposed save-the-date, flyers and/or brochure with your application so that it can be approved prior to printing. **(Must have date of activity, topics, lecturer, objective of the topic, accreditation, disclosures and ADA statements)**

15. Budget – **Will a registration fee be charged?** ☐ No ☐ Yes If yes, how much? _____

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

If yes, list companies are you applying to:

CME disclosure, budget and commercial support forms can be downloaded from our website – http://138.5.157.71/cme/applications.html

Signature: Activity Director_____ **Date:** _____

Be sure to include the following with your application:

- ☐ **Yearly Application Fee (RSS $250, $350 joint) (Annual conferences $1500, other- please call)**
- ☐ **A completed and signed application**
- ☐ **Signed Letter of Agreement (1st time activities only and all annual conferences)**
- ☐ **Planning minutes**
- ☐ **Supporting documentation for gaps identified**
- ☐ **A draft of your brochure or/and flyer**
- ☐ **Preliminary Budget Plan**
- ☐ **Sample Evaluation Form**
- ☐ **CME Disclosure Form (s)**
- ☐ **Commercial Support Form (s) (if applicable)**

Return the completed application and **Make checks payable to *SUNY OCME***

Payment Information

Check # _____

Please charge my credit card: Visa MasterCard Discover Amount Authorized $_____

Cardholder's Name (as it appear on card): _____

Card Number # _____ Expiration Date: _____

***3 Digit Security Code _____**

Signature_____

I hereby authorize SUNY Downstate to charge my credit card for the amount indicated above.

The Office of Continuing Medical Education
SUNY Downstate Medical Center
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Brooklyn, NY 11203

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E-mail ocme@downstate.edu

FOR OCME USE ONLY:

☐ **Approved for AMA/PRA Category 1** ☐ **Disapproved** **Justification: _____**

CME Director _____