SUNY Downstate Medical Center | Office of Continuing Medical Education

CME FORMS

The following Accreditation Statement must appear on all distributed CME Activity Materials and Brochure/ Flyers.

The State University of New York (SUNY) Downstate Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
SUNY Downstate Medical Center designates this educational activity for a maximum of _____category 1 credit toward the American Medical Association Physician's Recognition Award (AMA / PRA). Each physician should claim only those credits that he / she actually spent in the activity.

The following Disclaimer Statement should be included in your Brochure/Flyer.

SUNY Downstate Medical Center and its affiliates are committed to providing educational activities that are objective, balanced and as free of bias as possible. All participating faculty are expected to disclose to the audience, verbally or in writing, any commercial relationships that might be perceived as a real or apparent conflict of interest related to the content of their presentations, i.e. with companies whose products or services are related to the subject matter of the presentation; or products in the research and development phase.

ADA Statement (for conference brochures)
Special Needs: In accordance with the Americans with Disabilities Act, (*name of facility*) seeks to make this conference accessible to all. If you have a disability which might require special accommodations, please contact.... or e-mail your needs to:...

If you are planning a joint-sponsorhsip, enduring or Internet CME activity, please contact the office of CME for the proper accreditation statement.

SUNY Downstate Medical Center
Office of CME, Box 1244
450 Clarkson Avenue
Brooklyn, NY 11203

Tel. 718 270-2422
Fax 718 270-4563

www.downstate.edu / ocme
ocme@downstate.edu

SUNY Downstate Medical Center | Office of Continuing Medical Education

Regularly Scheduled Conference Letter of Agreement

To be in compliance with the Accreditation Council for Continuing Medical Education (ACCME), all Activity Directors must comply with the mission of the Office of CME (OCME) at SUNY Downstate Medical Center and the AMA's definition of CME. Approval for category 1 certification depends on the following conditions:

1. The OCME must be involved in the initial planning stages of the CME activity for which category 1 certification is being requested.
2. The planned activity must conform to the AMA's definition of CME***, "CME consists of educational activities that serve to maintain, develop, or increase the knowledge, skills and professional performance and relationships a physician uses to provide services for patients, the public, or the profession."*** The content or format of a CME activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest. Presentations and activity materials must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the CME educational materials or content includes trade names, where available, trade names from several companies should be used, not just trade names from a single company.
3. *D*ocumentation of needs assessment must be part of planning and attached to the Certification Request Form and sent to our office.
4. The educational objectives for each activity must be stated. The objectives should relate to the need and tell participants what they will learn by attending the program.
5. The planning of the activity must be documented in the form of minutes, schedule of topics, speakers and format.
6. The target audience must be defined and stated.
7. Speaker Disclosure

   All individuals who are in a position to control the content of an educational activity disclose all relevant financial relationships with any commercial interest **within the past 12months.** This includes, but is not limited to: activity medical directors, planning committee members, expert / peer reviewers, authors, faculty / speaker / presenters, moderators, panel members, and administrative support staff. Any individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a faculty / speaker / presenter, or an author of CME program, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the activity. Products or procedures being discussed that are off-label, unlabeled, experimental, and / or investigationaland <u>not</u> FDA approved must be disclosed. Including any limitations on the information that is presented, such as data that are preliminary or that represent ongoing research, interim analyses, and / or unsupported opinion.
8. A Preliminary Budget Plan must be filled out and returned with the CME Certification Request Form. All anticipated income and expenses, including the OCME fee must be disclosed. A Final Budget Form must be filled out two weeks following the end of the activity.
9. Commercial Support
   a. A Commercial Support Form must be filled out if a commercial organization provides funding of any sort to the activity. The form must be signed by the company representative and the activity Director and returned to the OCME.
   b. All commercial support funds are to be paid directly to the OCME or to the Department presenting the activity. Speakers may NOT be paid directly by commercial companies for any related expenses to the program. This includes travel, honorarium, gifts, etc. Please review OCME policy omn commercial support.
10. All CME activities requesting category 1 certification must be evaluated.
11. Any audio or video of the program for later distribution must be approved by the Office of CME. Additional fees will be applied.
12. The Activity Director must assure that the activity is HIPAA Compliant and agree to obtain all necessary copyright permission(s) for any portion of the CME activity materials that is not their original work.

13. Program Announcement

- ***a.*** Brochures and announcement material should have the statement of need, educational objectives and the intended audience.
- b. You may not indicate on the brochure or flyer that you have applied for credit or state the number of credits applied for until the Office of CME has issued approval.
- c. The Office of Continuing Medical Education at SUNY Downstate Medical Center as the accredited provider must be prominently displayed as the SPONSOR on the front of the brochure or flyer and your department as the PRESENTER of the activity.
- d. The educational format and course outline must be defined on the brochure.
- e. Registration fee and location of the activity must be present
- f. Acknowledgement of any type of support by commercial companies must be identified on the brochure, and / or your flyer.
- g. Your flyer must indicate the speaker disclosures and any off-label usage.
- h. The Final Draft of the brochure must be reviewed and approved by the OCME before printing.
- i. The following Accreditation and Disclaimer Statements must appear on all distributed CME activity brochures and flyers. If you are planning a joint-sponsorship activity, contact the Office of CME for the proper accreditation statement.

ACCREDITATION STATEMENT

The State University of New York (SUNY) Downstate Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
SUNY Downstate Medical Center designates this educational activity for a maximum of _____ category 1 credits toward the American Medical Association Physician's Recognition Award (AMA/PRA). Each physician should claim only those credits that he/she actually spent in the activity.

Disclaimer Statement

SUNY Downstate and its affiliates are committed to providing educational activities that are objective, balanced and as free of bias as possible. All participating faculty are expected to disclose to the audience, verbally or in writing, any commercial relationships that might be perceived as a real or apparent conflict of interest related to the content of their presentations, i.e. with companies whose products or services are related to the subject matter of the presentation; or products in the research and development phase.

ADA Statement

Special Needs: In accordance with the Americans with Disabilities Act, SUNY Downstate Medical Center seeks to make this conference accessible to all. If you have a disability which might require special accommodations, please contact.... or e-mail your needs to:….

14. At the conclusion of the activity, attendance sheets, a final budget form and a summary of the activity evaluations must be forwarded to our office. Certificates of Attendance will be mailed to activity participants listed on the attendance sheets by the Office of CME.
15. The fee for this CME activity is $150 per year. CME credit will be given as of the date the Credit Request Form is received by the OCME. A $20 fee will be charged for each CME Certificate and / or transcript issued.
16. We require all CME activity announcements, schedules, attendance, speaker disclosures forms, commercial support forms and evaluations at the end of each month. At the conclusion of the academic year, a final budget form and a summary of the activity evaluations must be forwarded to our office. The OCME will issue all certificates of attendance

PLEASE SIGN AND RETURN WITH YOUR CERTIFICATIONT REQUEST FORM.

As the Activity Director for the CME Activity titled _____

_____

from _____to _____. I have read and understand the essential requirements for

Category I credit approval listed on the RSC Letter of Agreement and agree to forward all the required documentation.

_____

CME Activity Director Signature ***Date***

SUNY Downstate Medical Center | Office of Continuing Medical Education

Live Annual Conference/Symposium Letter of Agreement

To be in compliance with the Accreditation Council for Continuing Medical Education (ACCME), all Activity Directors must comply with the mission of the Office of CME at SUNY Downstate Medical Center and the AMA's definition of CME. Approval for category 1 certification depends on the following:

1. The OCME must be involved in the initial planning stages of the CME activity for which category 1 certification is being requested.
2. The planned activity must conform to the AMA's definition of CME, ***"CME consists of educational activities that serve to maintain, develop, or increase the knowledge, skills and professional performance and relationships a physician uses to provide services for patients, the public, or the profession."*** The content or format of a CME activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest. Presentations and activity materials must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the CME educational materials or content includes trade names, where available, trade names from several companies should be used, not just trade names from a single company.
3. *D*ocumentation of needs assessment must be part of planning and attached to the Certification Request Form and sent to our office.
4. The educational objectives for each activity must be stated. The objectives should relate to the need and tell participants what they will learn by attending the program.
5. The planning of the activity must be documented in the form of minutes, schedule of topics, speakers and format.
6. The target audience must be defined and stated.
7. Speaker Disclosure

   All individuals who are in a position to control the content of an educational activity disclose all relevant financial relationships with any commercial interest **within the past 12months.** This includes, but is not limited to: activity medical directors, planning committee members, expert / peer reviewers, authors, faculty / speaker / presenters, moderators, panel members, and administrative support staff. Any individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a faculty / speaker / presenter, or an author of CME program, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the activity. Products or procedures being discussed that are off-label, unlabeled, experimental, and / or investigationaland <u>not</u> FDA approved must be disclosed. Including any limitations on the information that is presented, such as data that are preliminary or that represent ongoing research, interim analyses, and / or unsupported opinion.
8. A Preliminary Budget Plan must be filled out and returned with the CME Certification Request Form. All anticipated income and expenses, including the OCME fee must be disclosed. A Final Budget Form must be filled out two weeks following the end of the activity.
9. Commercial Support
   a. A Commercial Support Form must be filled out if a commercial organization provides funding of any sort to the program. The form must be signed by the company representative and the Activity Director and returned to the OCME.
   b. All commercial support funds are to be paid directly to the OCME or to the Department sponsoring the program. Speakers may NOT be paid directly from commercial companies for any related expenses to the program. This includes travel, honorarium, etc.
10. All CME activity-requesting category 1 certification must be evaluated.
11. Any audio or video of the program for later distribution must be approved by the Office of CME. Additional fees will be applied.
12. The Activity Director must assure that the activity is HIPAA Compliant and agree to obtain all necessary copyright permission(s) for any portion of the CME activity materials that is not their original work.

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13. Program Announcement
    a. Brochures and announcement material should have the statement of need, educational objectives and the intended physician audience.
    b. You may not indicate on the brochure or flyer that you have applied for certification or state the number of certifications applied for until the Office of CME has issued approval.
    c. The Office of Continuing Medical Education at Downstate Medical Center as the accredited provider must be prominently displayed as the SPONSOR on the front of the brochure or flyer and your department as the PRESENTER of the activity.
    d. The educational format and course outline must be defined on the brochure.
    e. Registration fee and location of the activity must be present
    f. Acknowledgement of any type of support by commercial companies must be listed in the activity announcement and brochure,
    g. The Final Draft of the brochure must be reviewed and approved by the OCME before printing.
    h. The following Statements must appear on all distributed CME activity brochures and flyers.

ACCREDITATION STATEMENT

The State University of New York (SUNY) Downstate Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
SUNY Downstate Medical Center designates this educational activity for a maximum of _____ category 1 credits toward the American Medical Association Physician's Recognition Award (AMA/PRA). Each physician should claim only those credits that he/she actually spent in the activity.

Disclaimer Statement

SUNY Downstate and its affiliates are committed to providing educational activities that are objective, balanced and as free of bias as possible. All participating faculty are expected to disclose to the audience, verbally or in writing, any commercial relationships that might be perceived as a real or apparent conflict of interest related to the content of their presentations, i.e. with companies whose products or services are related to the subject matter of the presentation; or products in the research and development phase.

ADA Statement

Special Needs: In accordance with the Americans with Disabilities Act, SUNY Downstate Medical Center seeks to make this conference accessible to all. If you have a disability which might require special accommodations, please contact.... or e-mail your needs to:…

14. At the conclusion of the activity, attendance sheets, a Final Budget Form and a summary of the activity evaluations must be forwarded to our office. Certificates of Attendance will be mailed to activity participants listed on the attendance sheets by the Office of CME for a fee of $20 per certificate.

15. The fee for a live annual conference is $1500 if it is received by the OCME twelve (12) weeks prior to the start of the activity. A late fee of $200 will applied if received six weeks before date of activity. ANY Certification Request Form received less than thirty (30) days before the conference begins will not be accepted. Additional administrative fees will be applied if conference management services are requested from the OCME.

Please make a copy for your file, sign and return this form with the CME Certification Request Form.

As the Activity Director for the CME Activity titled _____

occurring on _____. I have read and understand the essential requirements for Category I certifications approval listed on the CME Live / Annual Letter of Agreement and agree to forward all the necessary documentation.

_____

CME Activity Director Signature ***Date***

SUNY Downstate Medical Center | Office of Continuing Medical Education

PRELIMINARY BUDGET PLAN

To be in compliance with the ACCME, this form must be completed and signed. If commercial support is received, a signed Commercial Support Letter of Agreement must be submitted for each commercial supporter. You are reminded that speaker honoraria may not be paid directly to the speaker from the commercial supporter.

Organization/department name | Title of activity | Date

INCOME		EXPENSES	
Total Commercial Support funding:		Program material (certificates, name tags, signs, etc)	
Ttoal funds from your department:		Handout materials (evaluations, abstracts, agendas, etc)	
Participant fees, registration of _____ at a registration fee of $_____ each..		Mailing (postage, labels)	
Total income from participants fees:		Faculty (honoraria, car service)	
Other:		Presentation materials (film, photography, slides)	
		Audio visual (equipment, personnel, etc)	
		Catering	
		Hotel (including meals, breaks, and gratuities)	
		CME Fee	
		Other Expenses	
TOTAL INCOME:		**TOTAL EXPENSES:**	

_____ _____

CME Activity Director signature | Date

COMMERCIAL SUPPORT LETTER OF AGREEMENT

This Letter of Agreement, entered into this _____day of _____ , 200__ by and among SUNY Downstate Medical Center acting for and on behalf of the Educational Partner named below (if applicable); and the Commercial Interest named below, witnesses the following:

CME Activity Title _____

Date of Activity: _____

Location of Activity _____

Commercial Company name: _____

Support Amount: _____

GRANT MADE PAYABLE TO: ☐ OCME ☐ Downstate Clinical Department ☐ Educational Partner

GENERAL CONDITIONS (BASED ON ACCME STANDARDS)

STANDARD 1: Independence

1.1 A CME provider must ensure that the following decisions were made free of the control of a commercial interest. The ACCME defines a "commercial interest" as any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.(a) Identification of CME needs; the Commercial Interest may not be the agent providing the CME activity to the learners.

STANDARD 3: Appropriate Use of Commercial Support

3.1 The provider must make all decisions regarding the disposition and disbursement of commercial support. **3.2** A provider cannot be required by a commercial interest to accept advice or services concerning teachers, authors, or participants or other education matters, including content, from aeducation matters, including content, from a commercial interest as conditions of commercial interest as conditions ofcontributing funds or services.contributing funds or services. **3.3** All commercial support associated with a CME activity must be given with the full knowledge and approval of the provider. **3.8** The provider, the joint sponsor, or designated educational partner must pay directly any teacher or author honoraria or reimbursement of out-of–pocket expenses in compliance with the provider's written policies and procedures. **3.9** No other payment shall be given to the director of the activity, planning committee members, teachers or authors, joint sponsor, or any others involved with the supported activity.

STANDARD 4: Appropriate Management of Associated Commercial Promotion

4.1 Arrangements for commercial exhibits or advertisements cannot influence planning or interfere with the presentation, nor can they be a condition of the provision of commercial support for CME activities. **4.2** Product-promotion material or product-specific advertisement of any type is prohibited in or during CME activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Live (staffed exhibits, presentations) or enduring (printed or electronic advertisements) promotional activities must be kept separate from CME. **4.3** Educational materials that are part of a CME activity, such as slides, abstracts and handouts, cannot contain any advertising, trade name or a product-group message. **4.4** Print or electronic information distributed about the non-CME elements of a CME activity that are not directly related to the transfer of education to the learner, such as schedules and content descriptions, may include product promotioncontent descriptions, may include product promotion material or product-specific advertisement.material or product-specific advertisement. **4.5** A provider cannot use a commercial interest as the agent providing a CME activity to learners, e.g., distribution of self-study CME activities or arranging for electronic access to CME activities.

STANDARD 5. Content and Format without Commercial Bias

5.1 The content or format of a CME activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest. **5.2** Presentations must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the CME educational material or content includes trade names, where available trade names from several companies should be used, not just trade names from a single company.

STANDARD 6.Disclosures Relevant to Potential Commercial Bias/Relevant financial relationships of those with control over CME content

6.1 An individual must disclose to learners any relevant financial relationship(s), to include the following information: The name of the individual; · The name of the commercial interest(s);· The nature of the relationship the person has with each commercial interest. **6.2** For an individual with no relevant financial relationship(s) the learners must be informed that no relevant financial relationship(s) exist. **6.3** The source of all support from commercial interests must be disclosed to learners. When commercial support is 'in-kind' the nature of the support must be disclosed to learners. **6.4** 'Disclosure' must never include the use of a trade name or a product-group message. **6.5** A provider must disclose the above information to learners prior to the beginning of the educational activity.

The Commercial Supporter agrees to abide by all requirements of the ***ACCME Standards for Commercial Support of Continuing Medical Education.***

The Accreditated Provider agrees to:

abide by all requirements of the ACCME *Standards for Commercial Support of Continuing Medical Education;*acknowledge educational support from the commercial company in program brochures, syllabi and other program materials; and upon request, furnish the commercial supporter with a report concerning the expenditure of funds provided.

Accredited Provider: **SUNY Downstate Medical Center** **Tax ID Number :14-6013200**

Contact Person _____

E-mail Address _____

Phone Number & Fax Number _____

Educational Partner (Facility/Dept.):

Contact Person _____

E-mail Address _____

Phone Number & Fax Number _____

Commercial Interest:

Contact person _____

E-mail Address _____

Phone Number & Fax Number _____

AGREED:

Accredited Provider

_____

Signature / Date
Edeline Mitton, MEd, CPP
Director, OCME

Educational Partner (if applicable)

_____

Signature / Date
Print Name _____
Title _____

Commercial Interest

_____

Signature / Date

_____

Print Name / Title

SUNY Downstate Medical Center | Office of Continuing Medical Education

<Date>

<address1>
<address2>
<address3>

Dear <insert name of Faculty Member/Author/Teacher>:

RE: Relevant Financial Relationships with Commercial Interests

We are pleased that you are willing and able to participate in our CME activity scheduled for <Insert date> at the <insert location> in <insert city>.

SUNY Downstate Medical Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME). As such, we have made the choice to meet the ACCME's expectations for our practice of continuing medical education. Our accreditation is important to us. We look forward to working together to provide CME at the highest standard.

The activity we have asked you to participate in is based on <insert identified need>. We have planned the activity so that <insert expected result>. The purpose or objective of your contribution is <insert purpose or objective> and we expect the content will relate to <insert summary of content>.

SUNY Downstate Medical Center has implemented a process where everyone who is in a position to control the content of an education activity has disclosed to us all relevant financial relationships with any commercial interest (see below for definition). In addition, should it be determined that a conflict of interest exists as a result of a financial relationship you may have, this will need to be resolved prior to the activity. In order to do this, please provide us with the following information by <insert date>. This information is necessary in order for us to be able to move to the next steps in planning this CME activity. If you refuse to disclose relevant financial relationships, you will be disqualified from being a part of the planning and implementation of this CME activity.

First, on the attached form, list the names of proprietary entities producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies with which you or your spouse/partner have, or have had, a relevant financial relationship within the past 12 months. For this purpose we consider the relevant financial relationships of your spouse or partner that you are aware of to be yours.

Second, describe what you or your spouse/partner received (ex: salary, honorarium etc). SUNY Downstate Medical Center does NOT want to know how much you received.

Third, describe your role.

Again, thank you for agreeing to work with us in this CME activity. We look forward to this activity making an important contribution to the continuing professional development of our learners and to your professional practice.

Sincerely,
<Insert Name>
<Insert Job Title>

Financial relationships

Financial relationships are those relationships in which the individual benefits by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g., stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit. Financial benefits are usually associated with roles such as employment, management position, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership, and other activities from which remuneration is received, or expected. ACCME considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner.

SUNY Downstate Medical Center | Office of Continuing Medical Education

SPEAKER DISCLOSURE FORM

Name of Organization _____

Title of Activity _____

Date of Activity _____

Activity Director _____

Speaker's Name _____

Institution _____

Please return this form to: _____

Please return this form by (date): _____

I understand that the SUNY Downstate Medical Center endorses the Guidelines of the American Medical Association and the Standards of the Accreditation Council for Continuing Medical Education. Therefore, faculty or anyone involved with the presentation content for a CME activity disclose to participants the presence of any relationships with commercial companies whose products are discussed in the faculty member's presentation. **Significant financial relationships include receiving (from a company) research grants, consultancies, honorarium and travel, or other benefits or having self-managed equity in a company. Individuals with substantive conflicts of interest cannot plan or speak. Faculties are also expected to openly disclose any off-label, experimental, or investigational use of drugs or devices discussed in their presentation. Financial relationhips of your spouse or partner, which you are aware of, for this purpose, are considered yours.**

In regard to this requirement (please check one)

☐ No disclosure
☐ I have a financial relationship with one or more organizations listed below.

Organization/Role **Relationship (please check one)**

_____ ☐ Consultant
_____ ☐ Grants/research support
_____ ☐ Honorarium
_____ ☐ Stock Holder
_____ ☐ Other_____

(If more companies are to be listed, continue on an attached separate sheet)

I will discuss a drug or medical device that has not been approved by the FDA. ☐ Yes ☐ No

If yes, drug or/and device name _____
Uses _____

_____ _____
Signature: Date:

SUNY Downstate Medical Center | Office of Continuing Medical Education

ATTESTATION FORM

Independent Content Validation, Fair Balance, and Level of Evidence

ACCME Content Validation Statement:

1. All the recommendations involving clinical medicine in a CME activity must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients.
2. All scientific research referred to, reported or used in CME in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection and analysis.

Based on the statement below, please attest to the following:

☐ I understand that my CME presentation materials such as slides/abstract/monograph, etc. may be peer reviewed prior to the activity occurring (or being released) for fair balance and to validate content and may be edited accordingly.

☐ I understand that my CME presentation will be evaluated by participants for fair balance (e.g. degree of commercial bias) and that enduring materials (if applicable) will be peer-reviewed for fair balance and validation of content and may be edited accordingly.

☐ I attest that any and all clinical recommendations that I make for patient care as part of my planning and/or CME activity materials will be based on the best available evidence, that a balanced view of therapeutic options will be given, and the content will be in accordance with ACCME's Content Validation Statement. I will also provide the level of evidence for said recommendations in the CME activity materials.

HIPAA, Copyright Permission(s), and Opportunity for Debate

☐ I attest that my CME activity materials will be HIPAA compliant.

☐ I agree to obtain the necessary copyright permission(s) if any portion of my CME activity materials that I prepare is not my original work or for which I do not hold the copyright.

☐ I agree to provide meaningful opportunity for questioning or scientific debate (live presentation).

Signature_____ Date_____

SUNY DOWNSTATE Medical Center | Office of Continuing Medical Education

SPEAKER PAYMENT INFORMATION

PLEASE FILL OUT THE INFORMATION BELOW FOR ALL PAYMENTS TO BE REIMBURSED BY THE OFFICE OF CME.

Name of Organization _____

Title of Activity _____

Date of Activity _____

Activity Director _____

Contact person _____ **Telephone** _____

Pharmaceutical Company _____

Pharmaceutical Rep's name _____

Rep's telephone _____ **beeper/cell number** _____

Rep's e-mail _____

Grant Amount _____

Purpose of payment _____

Speaker's Name _____

Speakers' Institution _____

Address (check will be sent to that address) _____

Address _____

City, State, Zip _____

Telephone _____ **Fax** _____

Social Security _____

Contact person _____

NOTES: _____

SUNY DOWNSTATE Medical Center | Office of Continuing Medical Education

RSC EVALUATION

Thank you for participating in this CME activity. The Office of Continuing Medical Education would like to know if this was a valuable learning experience for you, and would appreciate your responses to the following questions. Title of

Activity _____ Date_____

1=Poor 2=Below Average 3=Average 4=Above 5=Outstanding

Presenter:_____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:_____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

	Yes	Somewhat	No		
Were the objectives of the CME activity met?	☐	☐	☐		
Were the speakers knowledgeable?	☐	☐	☐		
Were the topics presented relevant to your needs?	☐	☐	☐		
Was enough discussion time allowed?	☐	☐	☐		
Did you:					
develop new clinical skills?	☐	☐	☐		
develop interpretive and diagnostic skills?	☐	☐	☐		
acquire new information on the subject?	☐	☐	☐		
receive practical review of the subject?	☐	☐	☐		
Did you have the opportunity to discuss practice-relevant issues with the speakers?	YES ☐	NO ☐			
Will you make any changes in your clinical practice based on information presenred at this activity?	YES ☐	NO ☐			
Was there any apparent conflict of interest shown by the speaker(s)? If yes, please explain.	YES ☐	NO ☐			
Was the meeting room conduciveness to learning?	YES ☐	NO ☐			
Was the food service adequate?	YES ☐	NO ☐			
How was the methods used by faculty to facilitate learning?	1	2	3	4	5
Lenght of activity	Too short ☐	Adequate ☐	Too long ☐		
General Comments					
Name (optional):					
Affiliations/Specialty:	☐ Hospital	☐ Private practice	☐ Academic/ Teaching	☐ Managed Care	
Other:	☐ MD/DO	☐ Nursing	☐ Student	☐ Other Healthcare Professional	

SUNY DOWNSTATE Medical Center | Office of Continuing Medical Education

ANNUAL CONFERENCE EVALUATION

Thank you for participating in this CME activity. The Office of Continuing Medical Education would like to know if this was a valuable learning experience for you, and would appreciate your responses to the following questions. Title of

Activity ____ Date__________________________________

1=Poor **2=Below Average** **3=Average** **4=Above** **5=Outstanding**

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Presenter:____

The presenter's overall presentation was	1	2	3	4	5
The presenter's ability to respond to questions was	1	2	3	4	5

Indicate the reason you came to the meeting:	**Please check appropriate box(s).**				
to develop clinical skills	☐				
to develop interpretive and diagnostic skills	☐				
to acquire new information on the subject	☐				
to review the subject	☐				
to meet CME requirements	☐				
Did you:	**Yes**	**Somewhat**	**No**		
develop new clinical skills?	☐				
develop interpretive and diagnostic skills?	☐				
acquire new information on the subject?	☐				
receive practical review of the subject?	☐				
Indicate which of the teaching formats helped you reach your goal:					
Lectures					
question/answer sessions					
interpretation panels					
workshops/small group sessions					
Did you have the opportunity to discuss practice-relevant issues with the speakers?	YES ☐	NO ☐			
Will you make any changes in your clinical practice based on information presenred at this activity?	YES ☐	NO ☐			
Was there any apparent conflict of interest shown by the speaker(s)? If yes, please explain.	YES ☐	NO ☐			
Was the meeting room conduciveness to learning?	YES ☐	NO ☐			
Was the food service adequate?	YES ☐	NO ☐			
How was the methods used by faculty to facilitate learning?	1	2	3	4	5
Lenght of activity	Too short ☐	Adequate ☐	Too long ☐		
General Comments					
Name (optional):					
Affiliations/Specialty:	☐ Hospital	☐ Private practice	☐ Academic/ Teaching	☐ Managed Care	
Other:	☐ MD/DO	☐ Nursing	☐ Student	☐ Other Healthcare Professional	

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FORMS TO BE RETURNED AT THE END OF YOUR ACTIVITY.

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FINAL BUDGET FORM

Please complete both sides of this form and return to the OCME at the end of your activity. If commercial support was received, a signed Commercial Support Letter of Agreement must be submitted for each commercial supporter. You are reminded that speaker honoraria may not be paid directly to the speaker from the commercial supporter.

Organization\department name _____ Title of activity _____ Date _____

INCOME		EXPENSES	
Total Commercial Support funding:		Program material (certificates, name tags, signs, etc)	
Ttoal funds from your department:		Handout materials (evaluations, abstracts, agendas, etc)	
Participant fees, registration of _____ at a registration fee of $_____ each..		Mailing (postage, labels)	
Total income from participants fees:		Faculty (honoraria, car service)	
Other:		Presentation materials (film, photography, slides)	
		Audio visual (equipment, personnel, etc)	
		Catering	
		Hotel (including meals, breaks, and gratuities)	
		CME Fee	
		Other Expenses	
TOTAL INCOME:		**TOTAL EXPENSES:**	

Activity Director signature _____ **Date** _____

(See reverse side)

Name and address of faculty paid by commercial support	Amount of payment	Reason for payment	Company providing funds

Please reproduce this sheet if additional space is required.

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EXECUTIVE SUMMARY FORM

At the end of the CME activity academic year, complete this summary and return to the Office of CME. **PLEASE COMPLETE BOTH SIDES OF THIS FORM.**

Title of Activity _____ Type of Activity_____

Organization_____ Department_____

Name of Activity Director_____ Date Covered_____

Indicate the total numbers of participants who attended your CME activity:

Number of Physicians_____
Number of Non-Physicians_____
Total number of participants_____

Please indicate the number of sessions if this is anRSC_____

The following (based on participant evaluations, input from faculty, staff and yourself) may be answered in number of responses or percentages.	Strongly Agree Excellent	Moderately Agree/Good	Disagree Poor
Were the objectives of the CME activity met?			
Were the desired results or expected outcome achieved?			
Did the topics presented have an impact on the audience to bring about behavioral changes in practicing medicine?			
Was the overall quality of the presentations favorable?			
Was the audience encouraged to ask questions and was enough discussion time allowed?			

What were the major strengths and weaknesses of this CME activity?

Would you make any changes in future CME activites based on feedback from this activity?

Please use this space to provide a general summary of the activity.

I certify that the appropriate Commercial Support and Speaker Disclosures were made.

Signature of Activity Director_____ Date_____