**Course Number and Course Name**

**Course Date**

**Required Information for Brochure**

**All Promotional material including brochures, announcements, save the date cards, e-mail blasts and website postings must be approved by our office and the Office of Public Affairs before being printed and distributed. Once you have a draft copy please send to our office for review.**

**Please notify our office once the ACCME accreditation statement and learning objectives have been added to the website so we can capture a screenshot to use as documentation.**

**The following information must be included in your registration brochure and approved before you go to print or posted on your website:**  a) accreditation statement, b) conflict resolution statement, c) activity description, purpose and intended/target audiences  d) list of planning committee members, e) learning objectives, f) non-discrimination statement, g) accommodation statement, h) acknowledgement to commercial and in-kind support and exhibitors, i) disclaimer statement, and j) policy on faculty and presenter disclosure,.

1. **Accreditation Statement:**

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the University of Oklahoma College of Medicine and the <ORGANIZATION>. The University of Oklahoma College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

The University of Oklahoma College of Medicine designates this live activity for a maximum of 0.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ADD MOC STATEMENT IF APPLICABLE

ADD ADDITIONAL CREDIT STATEMENTS IF APPLICABLE

1. **Conflict Resolution Statement:**

The University of Oklahoma College of Medicine, Office of Continuing Professional Development has reviewed this activity’s speaker and planner disclosures and resolved all identified conflicts of interest, if applicable.

1. **Activity Description, Purpose and Intended/Target Audience:**
2. **Activity Description:** (Insert description)
3. **Intended/Target Audience:**
4. **Planning Committee Members:**

Insert Name - **Course Director**

Insert Name - **Course Contact**

1. **Learning Objectives:**

Upon completion of this activity, participants will improve their competence and performance by being able to:

1. **Nondiscrimination Statement:**

The University of Oklahoma, in compliance with all applicable federal and state laws and regulations, does not discriminate on the basis of race, color, national origin, sex, sexual orientation, genetic information, gender identity, gender expression, age, religion, disability, political beliefs, or status as a veteran in any of its policies, practices or procedures. This includes, but is not limited to: admissions, employment, financial aid and educational services. Inquiries regarding non-discrimination policies may be directed to: Bobby J. Mason, Institutional Equity Officer, (405) 325-3546, bjm@ou.edu, or visit [www.ou.edu/eoo.](http://www.ou.edu/eoo.html)

1. **Accommodation Statement:**

For accommodations, please contact (insert Course Contact) at (405) xxx-xxxx or (insert email address) as soon as possible.

1. **Acknowledgement of Commercial and In-Kind Support**

**Commercial support** is financial, or in-kind, contributions given by a commercial interest, which is used to pay all or part of the costs of a CME activity.  A **commercial interest** is any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

Appropriate acknowledgement of all commercial and in-kind support will be given at the time of the educational activity.

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1. **Accreditation Council for Graduate Medical Education (ACGME)**

 **American Board of Medical Specialties (ABMS) Competencies**

LIST COMPETENCIES FROM APPLICATION

**Brochure must include an agenda, registration information and a registration form.**

Activity Name CME #XXXXX

Activity Date

**Online registration is highly recommended. To register online, go to** [**cme.ouhsc.edu**](https://ouhsc.cloud-cme.com)**.**

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Phone Fax Cell Phone (Required)

Date of Birth NPI Number

Emergency Contact Name Phone (\_\_\_\_)

Please provide an email address that you will be able to access. You will use this address to complete your evaluation and print your CME certificate.

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|  | Other Healthcare Providers  |  |
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