Course #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Traditional Live Activity Application**

**PLEASE NOTE*:***Applications must be typed and submitted electronically. This form is designed to collect all information necessary to plan and develop the proposed CME activity. Completion of all sections of this form is necessary to meet accreditation requirements. All speakers, moderators, authors, and teachers will be referred to as Presenters. The CPD staff is available to help you navigate this process.

**Section 1 of 8: Activity Description**

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity Information** | | | |
| **Title of Activity:** | | | |
| **Department/Division Name:** | | | |
| **Department/Society Website:** | | | |
| **Department/Society Mission Statement:** | | | |
| **Start Date:** | | **End Date:** | |
| **Facility/Location:** | | | |
| **Facility Address:** | | | |
| **Type of Activity** | | | |
| New (First offering)  Series | | | Previous Course #: |
| **Live Course** (symposium, workshop, conference)  A single activity offered only once in one location and not part of a series  A training program  One activity delivered at multiple locations on multiple dates over a fiscal year  Number of times offered: (estimate if unknown)\_\_\_\_\_\_\_\_\_\_\_  Date: Location:  Date: Location:  Date: Location: | | | |
| Will this activity/part of activity be webcast?  Yes, please provide URL:  No  Are you interested in archiving your activity presentation as a web-based CME-certified enduring materials (self-study)?  Yes  No | | | |
| **Providership:** | | | |
|  | **Direct Providership** (An activity organized by departments within the OU College of Medicine) | | |
|  | **Joint Providership** (An activity organized by entities outside the OU College of Medicine. Note: A pharmaceutical company or medical device manufacturer cannot be a provider.) | | |

**Traditional Live Activity Application**

**Section 2 of 8: Leadership and Administrative Support Staff**

NOTE: All individuals listed will be required to complete and sign a CME disclosure form and submit a curriculum vitae before the application will be approved.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Course Director(s)** The physician or basic scientist who has overall responsibility of planning, developing, implementing and evaluating the content and logistics of a certified activity. | | | | | |
| **First Name:** | | | | | **Middle Initial:** |
| **Last Name:** | | | | | **Degree(s):** |
| **Title:** | | **Affiliation:** | | | |
| **Department:** | | | | **Email:** | |
| **Cell Phone:** | | | **Office Phone:** | | |
| **Address:** | | | | | |
| **City, State and Zip:** | | | | | |
| **Receiving Honorarium & Amount:** | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Course Director Acceptance of Responsibilities** (Direct Sponsorship Only)  As course director, I have reviewed this application form and responsibilities for *AMA PRA Category 1 Credit™* for the period of July 1, 20\_\_ to June 30, 20\_\_. I attest that the information provided is complete and accurate. I agree to abide by the current ACCME and AMA accreditation requirements for planning, activity implementation and evaluation (including the Standards for Commercial Support) and the OU/COM Office of Continuing Professional Development policies and procedures for activities.  **In conjunction with OU/COM/CPD, I agree to (please check each selection to indicate that you have read and agree to the following):** | | | | | |
| Assist in resolving potential conflicts of interest prior to delivery of the educational series.  Conduct peer review of content and course materials to ensure that content is scientifically valid, evidence-based, balanced, and free from any commercial bias (regardless of whether the series itself receives any commercial support).  Disclose to learners: (1) any relevant financial relationships or the absence of a financial relationship, and (2) the source of all commercial support for the educational series.  Verify that disclosure of financial relationships and commercial support or lack of was made known to all participants prior to beginning of the educational series.  Maintain total separation of all educational and promotional activities.  Maintain records for six years.  **I understand that all activities certified by OU/COM/CPD are subject to periodic audit by OU/COM/CPD and/or the ACCME**.  **Course Director Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

**Traditional Live Activity Application**

**Section 2 of 8: Leadership and Administrative Support Staff**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Co-Course Director (optional)** The individual who shares responsibilities for planning the certified activity. Designating an Activity Co-Director is optional, but strongly encouraged, for a joint-providership activity. | | | | | | |
| **First Name:** | | | | | | **Middle Initial:** |
| **Last Name:** | | | | | | **Degree(s):** |
| **Title:** | | | **Affiliation:** | | | |
| **Department:** | | | | | **Email:** | |
| **Cell Phone:** | | | | **Office Phone:** | | |
| **Address:** | | | | | | |
| **City, State and Zip:** | | | | | | |
| **Receiving Honorarium & Amount:** | | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Administrative Coordinator/Course Contact** (this is often the person that the CPD staff works with who takes care of the administrative details for the activity) | | | | | | |
| **First Name:** | | | | | | **Middle Initial:** |
| **Last Name:** | | | | | | **Degree(s):** |
| **Title:** | | | **Affiliation:** | | | |
| **Department:** | | | | | **Email:** | |
| **Cell Phone:** | | | | **Office Phone:** | | |
| **Address:** | | | | | | |
| **City, State and Zip:** | | | | | | |
| **Receiving Honorarium & Amount:** | | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
|  | | | | | | |
|  | Check here if the Administrative Coordinator/Course Contact is NOT involved with selecting presenters, topics, influencing content. | | | | | |
| **Medical Director (if different from Course Director)** | | | | | | |
| **First Name:** | | | | | | **Middle Initial:** |
| **Last Name:** | | | | | | **Degree(s):** |
| **Title:** | | | **Affiliation:** | | | |
| **Department:** | | | | | **Email:** | |
| **Cell Phone:** | | | | **Office Phone:** | | |
| **Address:** | | | | | | |
| **City, State and Zip:** | | | | | | |
| **Receiving Honorarium & Amount:** | | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |

**Traditional Live Activity Application**

**Section 3 of 8: Planning**

|  |  |  |
| --- | --- | --- |
| **Planning Committee, Reviewers and Patient Volunteers**  In addition to the activity medical director, co-director, and/or course contact, list the names, degrees, titles, affiliations and emails of persons chiefly responsible for the design and implementation of this activity. Use additional sheets if necessary. **NOTE: All individuals listed will be required to complete and sign a CME disclosure form and submit a curriculum vitae before the application will be approved.** | | |
| **First Name:** | | **Middle Initial:** |
| **Last Name:** | | **Degree(s):** |
| **Title** | **Affiliation** | **Email** |
| **Cell Phone:** | **Receiving Honorarium & Amount:** | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **First Name:** | | **Middle Initial:** |
| **Last Name:** | | **Degree(s):** |
| **Title** | **Affiliation** | **Email** |
| **Cell Phone:** | **Receiving Honorarium & Amount:** | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **First Name:** | | **Middle Initial:** |
| **Last Name:** | | **Degree(s):** |
| **Title** | **Affiliation** | **Email** |
| **Cell Phone:** | **Receiving Honorarium & Amount:** | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **First Name:** | | **Middle Initial:** |
| **Last Name:** | | **Degree(s):** |
| **Title** | **Affiliation** | **Email** |
| **Cell Phone:** | **Receiving Honorarium & Amount:** | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **First Name:** | | **Middle Initial:** |
| **Last Name:** | | **Degree(s):** |
| **Title** | **Affiliation** | **Email** |
| **Cell Phone:** | **Receiving Honorarium & Amount:** | **No**   **Yes, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_** |

Additional planning committee members attached

**Traditional Live Activity Application**

**Section 3 of 8: Planning (continued)**

|  |
| --- |
| **Building Bridges with Other Stakeholders** C20  Occasionally there are other internal and/or external stakeholders working on similar issues with which you can collaborate |
| Are there others within your organization working on this issue?  Yes:  Identify who:  QI/Patient Safety  Patients  Nurses  Pharmacists  Dentists  Social Workers  Physician Specialists  Primary Care Physicians  Outside Organizations, Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Are there external stakeholders working on this issue?  Yes, Identify who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  If yes, could they be included in the development and/or execution of this activity?  Yes, in what ways: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| **How will collaboration enhance the activity’s intended outcomes:** (Sample: Provide relevant knowledge and community resources) |

**Traditional Live Activity Application**

**Section 3 of 8: Planning (continued)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Target Audience** | | | | | | | |
| This activity primarily addresses the role of the practicing physician participant/learner as:  Clinician  Medical educator  Researcher  Administrator  Other (specify) \_\_\_\_\_\_\_\_\_ | | | | | | | |
| Expected audience/participant size \_\_\_\_\_ Percent of audience/participant expected to be physicians \_\_\_\_\_  Percent of other allied health professionals \_\_\_\_\_ Percent of other \_\_\_\_\_\_ | | | | | | | |
| Percent OUHSC Faculty \_\_\_\_ Percent Local \_\_\_\_ Percent Oklahoma \_\_\_\_\_  Percent Regional \_\_\_\_\_ Percent National \_\_\_\_ Percent International \_\_\_\_\_ | | | | | | | |
| Select all that apply (at least 1 box from geographic location, provider type, and specialty must be selected). | | | | | | | |
| **Geographic Location:** | | **Provider Type:** | | **Specialty:** | | | |
|  | Internal |  | Primary Care Physicians |  | All specialties |  | Oncology |
|  | Local |  | Specialty Physicians |  | Anesthesiology |  | Orthopedics |
|  | Regional |  | Pharmacists |  | Cardiology |  | Pediatrics |
|  | National |  | Psychologists |  | Dermatology |  | Psychiatry |
|  | International |  | Physician Assistants |  | Emergency Medicine |  | Radiology |
|  |  |  | Nurses |  | Family Medicine |  | Radiation Oncology |
|  |  |  | Nurse Practitioners |  | General Medicine |  | Surgery |
|  |  |  |  |  | Neurology |  | Other (specify): |
|  |  |  |  |  | OB/GYN |  |  |
| ***AMA PRA Category 1 CreditTM***and **Levels for New Procedures and Skills** C35 | | | | | | | |
| **Will this program teach new procedures and skills which may allow for expanded clinical privileges?**  No  Yes  **If yes,** please note that the AMA has established a system of four levels that reflect the education and training a physician has achieved in the new procedure. *(Levels 2-4 require additional instructions and feedback from the course director.)*  The four levels are: **(Select** **the level appropriate for this activity.)**  **Level 1.** Verification of attendance;   **Level 2.** Verification of satisfactory completion of course objectives;   **Level 3.** Verification of proctor readiness; and   **Level 4.** Verification of physician competence to perform the procedure. | | | | | | | |

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*ADD ABIM MOC TO THIS AREA\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Traditional Live Activity Application**

**Section 3 of 8: Planning (continued)**

|  |
| --- |
| **Please indicate how this educational program will align with OU/COM/CPD’s mission.** C3 **(Check all that apply)** The mission of the University of Oklahoma College of Medicine, Irwin H. Brown Office of Continuing Professional Development is to provide lifelong learning for physicians and other healthcare providers based on documented needs and professional practice gaps, utilizing evidence-based medicine fundamentals. Activities and educational interventions approved by the Office of Continuing Professional Development support desirable physician attributes including patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. These educational activities and educational interventions will result in changes in learner competence and performance, and ultimately lead to high quality patient care and improved patient outcomes.  Additionally, as an integral part of OU Medicine, the Office of Continuing Professional Development supports the institutions mission of leading healthcare in education, research and patient care. |
| Designed to address gaps in quality.  Designed to disseminate evidence-based knowledge and skills.  Designed to improve patient health status/metrics.  Designed to promote team work among health professions by including an inter-professional audience.  Designed to assist health care professionals in their pursuit of life-long learning in order to provide high quality health care.  Designed to improve competence in one or more of the six core competency areas  Planned to promote patient-centered care through interprofessional education  Promotes the practice of evidence-based medicine.  Other, please explain: |
| **Other credit** |
| **Are you applying for other credits such as ACPE, ANCC, AAFP, ACOG, CRNA, etc?**  Yes  No  If yes, please list which types: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Feedback** C2, C4 |
| **List all the suggestions from the past CME evaluation that you have incorporated in this new activity:** |

**Traditional Live Activity Application**

**Section 4 of 8: Independence**

|  |
| --- |
| **Disclosure of Financial Relationships** C7    It is the policy of the University of Oklahoma College of Medicine to ensure balance, independence, objectivity, and scientific rigor in all directly or jointly provided educational activities. Documentation showing that relationships with commercial supporters **are disclosed** to the participants, even if there is no relevant commercial support associated with this program must be sent to the CPD office.  In addition to presenters, all individuals who are in a position to control the content of the educational activity (course/activity directors, planning committee members, staff, teachers, moderators, reviewers and authors of CME) must disclose all relevant financial relationships they have with any commercial interest(s) as well as the nature of the relationship. Financial relationships of the individual’s spouse or partner must also be disclosed, if the nature of the relationship could influence the objectivity of the individual in a position to control the content of the CME. The ACCME describes relevant financial relationships as those in any amount occurring within the past 12 months that create a conflict of interest*.* ***Individuals who refuse to disclose will be disqualified from participation in the development, management, presentation, or evaluation of the CME activity*. *Failure to return a disclosure form is equal to refusing to disclose.***  The Disclosure, Attestation Statement (disclosure & resolution form) is the mechanism used by the CPD office to gather information about relevant financial relationships with commercial interests  Conflicts of Interest (COI) must be resolved **BEFORE the activity occurs**, preferably during the early planning stages.  **Two-step Disclosure Process: (must be completed by the course director or course contact)**  Step 1: The OU/COM/CPD office will email appropriate forms to all planning committee members to complete;  Step 2: Convey the disclosure & resolution information obtained to your activity participants in the following manner:   * Disclosure must be made to participants of all relevant financial relationships, and/or the lack of relevant financial relationships, prior to the start of the activity. * All presenters must begin their presentation with a disclosure slide that matches their information in the disclosure report and give a verbal disclosure * All moderators must give a verbal disclosure |
| **Attestation of Having Read the Commercial Support Policies and Procedures** |
| You must attest to the following: I have read the [ACCME’s Standards for Commercial Support](http://www.accme.org/requirements/accreditation-requirements-cme-providers/standards-for-commercial-support). I understand the standards and my role and responsibilities.  Yes  No please explain why? |

**Traditional Live Activity Application**

**Section 4 of 8: Independence (Continued)**

|  |  |
| --- | --- |
| **Commercial and In-Kind Support** C7, C8, C9, C10 | |
| **Will you apply for educational grants to help fund this activity?**  No Commercial Support, go to next section titled Exhibit Space.  Yes, please list below all grants for which you have applied for or which you plan to apply. Indicate the grant status. A properly executed letter of agreement (LOA) and a copy of the check must be sent to the CPD office. Each grant must be funded BEFORE the educational activity.  Identify the individual(s) who will be responsible for requesting commercial support (either via educational grants or in-kind donations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check here if this is the Course Director  or the administrative contact  **OR** provide the full name, title, and contact information (email, phone, fax, and mailing address) for the individual(s) requesting support from outside entities. | |
| **Name of company** | **Grant request funded?** |
|  | Yes  No  Pending |
|  | Yes  No  Pending |
|  | Yes  No  Pending |
|  | Yes  No  Pending |
|  | Yes  No  Pending |
|  | Yes  No  Pending |

More space is needed, a complete list of grants applied for is attached with the above information indicated.

**Traditional Live Activity Application**

**Section 4 of 8: Independence (Continued)**

|  |  |
| --- | --- |
| **Exhibit Space** | |
| **Do you plan to solicit exhibit fees?**  No Exhibitors, go to next section titled Attendees.  Yes, please provide a list below of companies you plan to invite.  Identify the individual(s) who will be responsible for requesting and coordinating the exhibits: \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check here if this is the Course Director  or the administrative contact  **OR** provide the full name, title, and contact information (email, phone, fax, and mailing address) for the individual(s) requesting support from outside entities.  Date for exhibitor set-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Times allotted for exhibits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Exhibit Costs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Name of Company** | **Amount of Exhibit Fee?** |
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|  |  |
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More space is needed, a complete list of grants applied for is attached with the above information indicated.

**Traditional Live Activity Application**

**Section 4 of 8: Independence (Continued)**

|  |
| --- |
| **Attendees** |
| **Will you be providing food/meals for the attendees/learners?**  Yes  No  If yes, please check all that apply:  Breakfast  Buffet  Boxed lunch  Plated meal  Dinner  Breaks  Snacks  Other: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How will this be funded? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Will you be providing items of value to the attendees/learners?**  Yes  No  If yes, please check all that apply:  Tote Bags  Lanyards  Pens  T-Shirts  USB Flash Drive  Can Cooler  Lip Balm  Key Light  Cap  Coffee Mugs  USB Flash Drive  Sunglasses  Flashlight  Magnetic Clips  Power Bank Cell Phone Charger  Bottle Opener  Tumbler with Straw  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How will this be funded? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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**Traditional Live Activity Application**

**Section 5 of 8: Curriculum Development**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Presenters, Speakers, Teachers, Moderators or Authors – Disclosure Information**  Provide a list of all the presenters, speakers, teachers, moderators, or authors that are known at this time. **Note: A disclosure form and curriculum vitae/bio is required for all. If not received by 3 weeks before activity, credit will be reduced.** | | | | | | |
| **Last Name** | **First Name** | **Professional Designation (MD, DO, PA, APN)** | **Email:** | **Cell Phone:** | **Affiliation** | **Receiving Honorarium & Amount** |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |
|  |  |  |  |  |  | Y $\_\_\_\_\_  N |

More space is needed, a complete list of topics, is attached with the above information indicated.

**Traditional Live Activity Application**

**Section 6 of 8: Promotion**

|  |
| --- |
| **Promotion Materials**  **Please note:** All promotional materials must be approved by the OU/COM/CPD office prior to distribution to potential participants. There are required elements and statements that must be used in all promotional materials. If you fail to get prior approval for the materials and elements are missing or are incorrect you will be required to make the necessary corrections and redistribute the materials to potential participants (even if this requires reprinting.)  **See: Brochure/Promotional Material Requirements and Statement Guide**  **Located in resources** |
| **How will notification of this educational activity be distributed to the participants prior to the activity?** (Select all that apply)  Department Website  Save the Date Postcard  Web Advertisements  Save the Date E-blast  Flyer/Announcement  Registration Brochure  E-blast with Announcement/Flyer  Facebook  Facebook  Instagram  Instagram  Twitter  Other: (please specify) |

**Traditional Live Activity Application**

**Section 7 of 8: Financial Information**

|  |
| --- |
| **Budget** |
| You must complete the preliminary budget.  A final budget that lists **ALL** expense items will be required at the end of the activity/academic year. Commercial support is also to be a line item on the budget. You will need to submit documentation for payment of all presenter expenses.  **Please note:** Companies that are defined as commercial interests by the ACCME are not allowed to pay any conference expenses directly. Commercial support can only be provided as educational grants with proper documentation in place.You must demonstrate through the budget and the accompanying documentation that the conference organizers paid all expenses directly. |
| **Sources of Revenue** |
| **Institutional/Organizational Funds (Internal department):**  Funding provided by university or by the CPD office recognized joint provider of the activity,  or % costs absorbed by the department/division/organization. \_\_\_\_ %  **Commercial Support (Educational Grants):**  Funding or “in-kind” services provided by commercial support (pharmaceutical company,  device manufacturer, etc.) Requires compliance with the Standards for Commercial Support. \_\_\_\_ %    **Exhibits:**  Fees paid by a vendor to display information about their company outside of the session room.  Requires Compliance with the Standards for Commercial Support. \_\_\_\_ %  **State or Federal Grant:** \_\_\_\_ %  **Participant Registration Fees:**  Fee paid to attend/participate in proposed activity. \_\_\_\_ %  **Other, identify:** \_\_\_\_ %  **TOTAL:** (must equal 100%) 100% |

This area has been deliberately left blank.

**Traditional Live Activity Application**

**Section 7 of 8: Financial Information (Continued)**

|  |  |  |
| --- | --- | --- |
| **Estimated Income**  Enter all sources of income. | | |
| **Category includes** | | **Enter Your Estimated ANNUAL/Program Amount** |
| Institutional/Organizational Funds (Internal Department) | | **$** |
| Commercial Support (Educational Grants) | | **$** |
| Exhibit Space | | **$** |
| State or Federal Grants | | **$** |
| Participant Registration Fees | | **$** |
| Other income | | **$** |
| **Total Estimated Income:** | | **$** |
| **Estimated Expenses**  Enter expenses ONLY in the lines that you incur costs of either direct/out of pocket costs, or time/effort costs. | | |
| **Category** | **Category includes** | **Enter Your Estimated ANNUAL/Program Amount** |
| **Activity Marketing** | | |
| Posters, Flyers, Invitations, etc. | Graphic designer, print preparation for marketing, education pieces, and signage | **$** |
| Mailing/Postage | Self-explanatory | **$** |
| **Faculty Related Expenses** | | |
| Honoraria | Honoraria for external faculty; Honoraria and fringe benefit rate for internal faculty (if applicable) | **$** |
| Faculty Expenses | Travel, hotel, per diem, misc expenses relating to activity | **$** |
| **Meeting Room Related Expenses** | | |
| Media & AV costs | AV Equipment, Labor, Audience Response System Equipment | **$** |
| Facilities Cost | Room rental fees for offsite activities | **$** |
| **Participant Related Expenses** | | |
| Catering/Food | Food/Catering for either planning committee meetings and/or conferences | **$** |
| Syllabus/Handouts | Direct cost for copying and binding of educational materials | **$** |
| **Accreditation/Certification Expenses** | | |
| CME Application Fees | CME application fees including Cloud processing fee, late/rush fees, fees for other credit | **$** |
| Activity Content Development | Time spent planning the content of the series | **$** |
| **Administrative Related Costs** | | |
|  | Pre-conference staff time, on-site staff time, post-conference staff time | **$** |
|  | Miscellaneous office supplies and equipment used in conjunction with this activity | **$** |
| **Refunds** | Registration refunds for overpayment and cancellations | **$** |
|  |  |  |
| **Miscellaneous Expenses** | | |
|  |  |  |
|  |  |  |
|  | **Total Estimated Expenses** | **$** |

**Traditional Live Activity Application**

**Section 8 of 8: Fees**

|  |  |  |
| --- | --- | --- |
| **Live/Traditional Activities Application Fees** | | |
|  | **Direct Providership**  with **no** commercial support or exhibits | **$1,000 - Payment Due with Application**  (An activity organized by departments within the OU College of Medicine) |
|  | **Direct Providership**  with commercial support and/or exhibits | **$2,500 - Payment Due with Application**  (An activity organized by departments within the OU College of Medicine) |
|  | **Joint Providership**  with **no** commercial support and/or exhibits | **$3,000 - Payment Due with Application**  (An activity organized by entities outside the OU College of Medicine) |
|  | **Joint Providership**  with commercial support and/or exhibits | **$4,500 - Payment Due with Application**  (An activity organized by entities outside the OU College of Medicine) |
| Additional Fees | | |
| **Additional Credits** | | $125 per credit (over 16 credits) |
| **3 Week Late Fee** | | $500 (All documentation including additional information for the online syllabus, signed disclosure forms, PowerPoint presentations and other requested documents must be received before the 3 week deadline) |
| **2 Week Late Fee** | | $500 (All documentation including additional information for the online syllabus, signed disclosure forms, PowerPoint presentations and other requested documents must be received before the 2 week deadline) |
| **Cloud Processing Fee**  (Invoiced after activity) | | A **$25** fee will be charged for each registrant (This includes: Planners, Speakers, Faculty, Exhibitors, and all attendees) The processing fee is waived for Residents. |
| **Peer Review/Content Validation**  (Invoiced after activity) | | $375 per hour |
| **Reimbursement of Credit Card Fees** (Invoiced after activity) | | 3% |
| **Letters of Agreement**  (Invoiced after activity) | | $100 (no charge if using OU/COM/CPD Letter of Agreement) |
| **Commercial Support Fee (grants)**  (Invoiced after activity) | | 5% |
| **Application Fee for Additional Types of Credit Fees** (PA, NP, PharmD) | | Application fees vary per specialty |
| **Processing Fee for CPD Office to Complete other types of Applications** | | $100 per hour |
| **Travel Expenses** (required audits/site visit) | | Will invoice for airfare, hotel, and Perdiem or mileage and toll if applicable. |

**Traditional Live Activity Application**

**Section 8 of 8: Fees (continued)**

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| **Registration Fees: CPD will manage the registration. Please provide the registration fees and deadline date information below.** | | | | | |
|  |  | Early Bird Registration Fee | | Early Bird Deadline Date | Registration Fee |
| Physicians: (MD, DO, Fellows) |  | |  | $ |
| Other Health Care Professionals: (PA, NP, etc.) |  | |  | $ |
| Speakers: |  | |  | $ |
| Residents: |  | |  | $ |
| Students: |  | |  |  |
| Other categories: (if applicable) |  | |  | $ |
| No registration refunds will be made after *<Date>.*  Written notification of cancellation must be postmarked on/or before *<Date>.*  Cancellation fee is $\_\_\_\_\_ | | | | |
|  | Conference/Hotel Information: Please enter location, cost, contact information. | |  | | |

**Traditional Live Activity Application**

**Section 8 of 8: Fees (continued)**

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| **Method of Payment:**  Payment must accompany the application. If off campus, please submit check made payable to OU/COM/CPD. Our Tax ID is 73 156 3627. OUHSC departments must pay by transfer. A rush fee will be charged for application approvals < 45 days plus an additional fee if approval is < 25 days before activity date. *(Fee information)* |
| **Check**: Made payable to OU/COM/CPD.  Send payment to: Office of Continuing Professional Development, 800 Stanton L. Young Blvd, Ste. 4000, Oklahoma City, OK 73104  **Electronic Funds Transfer (EFT)/Purchase Order (PO)**  **OUHSC Inter-Department Cost Transfer:** Please ask your business manager to initiate the cost transfers in PeopleSoft. This transaction must be initiated by your department. Our chartfield spread information is: MISCA, COM015, 00014, 00000. Please cc Ephelders Lipscomb at [Ephelders-lipscomb@ouhsc.edu](mailto:Ephelders-lipscomb@ouhsc.edu) on the email transfer request referencing course number and title.  Please indicate the exact activity title *(i.e., PICU Journal Club or Diabetes Update)* in the PeopleSoft text fields (Do not type 'CME ACTIVITY' 'RSS' or 'Journal Club' without identifying the department". It is important to use the actual title of the CME activity which includes the department name) to assure proper posting.  **Credit Card:**  Visa  MasterCard  Discover  Card# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Payment is not included, please explain. |

By signing this application, I attest that this activity will follow the ACCME Essentials Elements and Policies to the best of my ability and that I will pay the fees charged.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Program Director Date Signature of Department Head or Designee Date

**Submit completed form and all documentation electronically to** [**Susie-Dealy@ouhsc.edu**](mailto:Susie-Dealy@ouhsc.edu)

**(FOR OFFICE USE ONLY)**

**This course is approved for \_\_\_\_\_\_\_ *AMA PRA Category 1 Credit(s)™*.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Associate Dean for Continuing Professional Development Date

Not approved for *AMA PRA Category 1 Credit™* due to: \_\_Insufficient time before activity presentation \_\_Topics not within definition of CME

\_\_ Other

**Traditional Live Activity Application**

**Activity Development Worksheet**

A Planning Process to Incorporate ACCME’s Updated Accreditation Criteria

Using the information on your activity, develop and record your CME activity plan using the guidelines below.

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| Note about ACCME’s Standards for Commercial Support (SCS): integrate the SCS into the planning processes at every step. When initiating a planning process, take steps to ensure that:   1. All steps should be taken independent of commercial interests. 2. Everyone who is in a position to control content must disclose all relevant financial relationships with a commercial interest to the provider. 3. OU/CPD has implemented mechanisms to identify and resolve all conflicts of interest prior to the education activity being delivered to learners. |

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| **Planning Process C7** |
| 1. **Who identified the presenters and topics**:   Course Director  Co-Course Director  Course Contact  Medical Director  Planning Committee  Other (provide names): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. **What criteria were used in the selection of presenters?** (select all that apply)   Subject matter experts  Excellent teaching skills/effective communicator  Experienced in CME  Academic qualifications  Experienced in field  Recognized content  Other: \_\_\_\_\_\_\_   1. **Were any employees of a pharmaceutical company and/or medical device manufacturer involved with the identification of presenters and/or topics?**   No  Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. **Is there an external conference manager or other business involved with the program?**   No  Yes, this requires a copy of any other contract which should be attached to this  application.   1. **Do you use pre and post-test assessment of knowledge and skills in practice-based learning and improvement?**   No  Yes, please provide a sample. |

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| **Overall goals/objectives/purpose for the activity**  **1.**  **2.** |

**Activity Development Worksheet**

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| **Overall Program Professional Practice Gap** C2, C3(difference between the **actual** (what is) and **ideal** (what should be) practice behaviors with regard to professional and/or patient outcomes.)  **The gap should explain what the practice-based problem or issue is you identified for the targeted audience.**  Write the gap in terms of what these practitioners do not know and/or are unable or fail to do according to the latest evidence**.** | **This is a gap/need of:**  (Select all that apply)  **Please note:** Accredited CME is required to take participants beyond the knowledge-level. In order to meet the competence requirement, the participant should leave the activity with strategies that can be applied in practice. Knowledge is a necessary basis of competence and the instruction may need to build this base if the needs assessment indicates a lack of knowledge. |
| **1.** | Knowledge  Competence  Performance  Patient Outcomes |
| **2.** | Knowledge  Competence  Performance  Patient Outcomes |
| Additional needs/gaps and objectives attached. | |
| **What methods were used to determine the need for this CME activity?** Must submit supporting documents. (Select two at minimum)  Survey results of potential learners  Identified new skills  Evaluations from previous CME activities  Literature review  Needed health outcomes  Quality improvement (QI) data  Federal or state government mandate  Other: \_\_\_\_\_\_\_ | |
| **Describe your CME activity:** | |

**Activity Development Worksheet**

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| **Identified Barriers/Factors Beyond Clinical Care that Effect Population Health** C27  What potential barriers/factors do you anticipate attendees may have incorporating new knowledge, competency, and/or performance objectives into practice? Select all that apply. (Select one at minimum) |
| **Physician Cognitive/Behavioral Barriers**  Knowledge  Awareness  Skill/expertise  Critical appraisal skills  **Physician Attitudinal Rational-emotive Barriers**  Efficacy/perceived competence  Perceived/outcome expectancy  Confidence in abilities  Authority  Accurate self-assessment  **Patient Barriers**  Patient characteristics  Adherence  **Support/Resource Barriers**  Time  Support  Costs/funding issues  Resources  System/process barriers  **Organizational Barriers**  System  Referral process  Team structure/work  Organizational supplies/tools  HR/workload/overload  None  Lack of opportunity  Other, please describe: |
| **Please describe how you/planning committee will attempt to address these identified barriers/factors in the educational activity.** **Example:** If the identified barrier is cost, you might attempt to address the barrier by stating, “the agenda/topics will allow for the discussion of cost effectiveness and new billing practices.” Consider the CPD office & Medical Library for providing scholarly information. |
| **Educational Reinforcement Tools** C32  What learning strategies will you include, or provide for the learners, in order to enhance your learners’ change in behavior as an adjunct to this activity?(Select one at minimum) |
| Chart Reminders  Evidence-based Order Sets  Facebook  Information Posted on Website  Instagram  Newsletter  Patient Education Materials  Patient Reminders Pocket Guidelines for Physicians  Patient Satisfaction Questionnaires  Pedometers or other Give-away Items  Peer to Peer Feedback  Pocket Guidelines for Physicians  Posters and Signs  Quantitative Surveys  Reference Guide  Screening Tools  Screensavers  Stickers  Twitter  Other, please describe: |
| **Desirable Attributes/Core Competencies** C6  American Board of Medical Specialties (ABMS)/Accreditation Council for Graduate Medical Education (ACGME) or Institute of Medicine (IOM) core competencies that will be addressed in this activity. Select all that apply. (Select one at minimum) |
| **Institute of Medicine Core Competencies**  Provide patient-centered care Work in interdisciplinary teams  Employ evidence-based practice  Apply quality improvement  Utilize informatics  **Accreditation Council for Graduate Medical Education (ACGME)**  **American Board of Medical Specialties (ABMS) Competencies**  Patient care  Medical knowledge  Practice-based learning/improvement  Interpersonal and communication skills  Professionalism  Systems-based practice |
| **Core Competencies for Interprofessional Collaborative Practice** C6  **Note: This section only needs to be completed if other types of continuing education credits are provided.**  Please select all of the Core Competencies for Interprofessional Collaborative Practice sponsored by the [Interprofessional Education Collaborative](https://ipecollaborative.org/uploads/IP-Collaborative-Practice-Core-Competencies.pdf) that will be addressed by this activity. |
| **Values/Ethics for Interprofessional Practice** – work with individuals or other professions to maintain a climate of mutual  respect and shared values  **Roles/Responsibilities** – use the knowledge of one’s own role and those of other professions to appropriately assess and  address the healthcare needs of the patients and populations served.  **Interprofessional Communication** – communicate with patients, families, communities, and other health professionals in a  responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of  disease.  **Teams and Teamwork** – Apply relationship-building values and the principles of team dynamics to perform effectively in  different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and  equitable.  **Other Competencies** – Other than those listed will be addressed. Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ACCME New Criterion**  Please identify any areas that your activity may or will address (if applicable): |
| Criterion 26 – Advances the use of health and practice data for healthcare improvement.  Criterion 29 – Sessions will optimize communication skills of learners.  Criterion 30 – Sessions will optimize technical and procedural skills of learners. |

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| **Evaluation and Outcomes**C3 C11 C36  The CPD Office will provide the online evaluation tool. We have required evaluation questions!  We will prepare a follow up survey to be sent 3-4 months following the activity. As part of the after activity action plan, you will have the opportunity to approve the follow-up survey. | | | |
| 1. **1. Additional Evaluation Questions:** If you have additional questions that you want included on the evaluation, please include them here. Questions must be received no later than 3 weeks before the activity. The CPD Office will send the evaluation results to the course director and course contact.   List additional questions:  **2. How will the evaluations be used?** *(Select as many as apply)*  The course director and planning committee will review the evaluations to determine whether  objectives were met  Feedback will be provided to the presenters  Evaluations will be used in planning future CME activities *(e.g. topics, presenters, format)* (Only check if additional questions regarding presenters are requested on the evaluation.  Other, please describe:  **Please identify additional evaluation tools which you will utilize. Reports from additional evaluation tools must be submitted to the CPD office.**  (Select all that apply) (Minimum of one required) | | | |
| **Knowledge/Competence** | | | |
|  | Audience response system (ARS) |  | Customized pre- and post-test |
|  | Other, please specify: | | |
| **Performance** | | | |
|  | Adherence to guidelines |  | Chart audits |
|  | Case-based studies |  | Direct observations |
|  | Customized follow-up survey/interview/focus group about actual change in practice at specified intervals |  | Other, please specify: |
| **Patient/Population Health** | | | |
|  | Observe changes in health status measures |  | Obtain patient feedback and surveys |
|  | Observe changes in quality/cost of care |  | Measure morbidity mortality rates |
|  | Other, please specify: | | |

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| **Educational Format** C3, C5  Based on the previous steps, what is the right format to use for the activity? What type of activity will it be (Live, Enduring Material, Internet, Other)? What will be the educational design of the activity (e.g. presentation, case studies, round table, and simulation)?  Remember to consider adult learning principles and the physician learning and change process.) Methods may vary; if so, please describe how they vary and the rationale for any variation. Interactive methods, those that require participants to interact with both the presenter and the material, are more effective at changing behavior and improving patient outcomes than are passive modalities. Keep didactic and other passive activities to a minimum (only appropriate to achieve changes in knowledge) and, if appropriate, intersperse didactic portions with interactive ones. **OU/CPD will not approve methods that are exclusively passive like straight lectures.** |
| Answer (Please select all that apply):  Procedure Lab  Hand-on Workshop  Homework Exercised  Reading Assignments  Demonstrations  Videodisk/Movie  Case Discussions  Work on Simulators/Models  Skills Testing  Question and Answer  Panel Discussion  Audience Response System  Video-Teleconference  Online Library  Small Group Discussion  Other, please describe: |
| **Educational Outcome(s)**  What are the expected outcomes for your learners of this activity in terms of their competence, performance, and/or patient outcomes? |
| (Check all that apply)  New knowledge (K)  Acquisition of strategies to incorporate new research into practice (K&C)  Acquisition of new protocols, policies, and procedures (K&C)  Critically appraise medical literature (C&P)  Change in diagnostic approach (C)  More appropriate referral to specialties (C&P)  Improve patient outcomes. (PO) (Describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |