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| Application for a New CE Activity | | | | | | | | | | |
| IMPORTANT:   * All questions must be answered unless otherwise indicated. Incomplete applications will not be processed. * Per our policy, there is a 45 day minimum requirement for new CME applications.  Applications may not be accepted with less than a 45 day lead time. Our accreditor, ACCME, is very strict in regards to compliance as it relates to disclosure forms, and our office needs adequate time to complete this process. * For your information, if your activity is a RSS, the first activity date approved for CME will be one that is outside the 45 day requirement. * Waiver requests may be made, in writing, by using the CE Application Waiver Request form. Approvals are not guaranteed. | | | | | | | | | | |
| 1. | Activity Title: | |  | | | | | | | |
| 2. | Activity Date: | |  | | | | | | | |
| 3. | Activity Time(s): | |  | | | | | | | |
| 4. | Is a copy of the agenda attached? | | | | | | | | | |
|  |  | Yes | | |  | | | No, agenda is pending | | |
| 5. | Activity Location: | |  | | | | | | | |
| 6. | Activity Type:[[1]](#footnote-1) (Select one per application.) | |  | Course | |  | Regularly-Scheduled Series (RSS) | |  | Internet Live Course |
|  | Enduring Material | |  | Internet Activity (Enduring Material) | |  | Committee Learning |

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| 7. | Is this activity directly related to the QA/QI committee and/or program? (Borgess & Bronson activities ONLY) *Is any part of this activity related to health measures tracked by the hospital (e.g. immunization or readmission rates)?* | | | | | | | | | | | | | |
|  |  | Yes | | |  | | No | | |  | | | | No, not applicable |
| 8. | Budget | | | | | | | | | | | | | |
| 8a. | Is the application fee attached?[[2]](#footnote-2) | | | | | | | | | | | | | |
|  |  | | Yes | | |  | | No, will be mailed separately | | |  | | No, not applicable | |
| 8b. | Is a copy of the activity budget attached? (Required if “Course” was selected in question #6.) | | | | | | | | | | | | | |
|  |  | | Yes | | |  | | No, not applicable | | | | | | |
| 8c. | Do you plan to charge attendees a registration fee? | | | | | | | | | | | | | |
|  |  | | Yes | | |  | | No | | | | | | |
| 8d. | Do you plan to have Commercial Support?[[3]](#footnote-3) | | | | | | | | | | | | | |
|  |  | | Yes (complete 8e) | | |  | | No (skip 8e) | | | | | | |
|  | A grant worksheet must be completed and submitted for each company listed in the table below. Grant worksheets are due a **minimum of 90 days prior to the activity.** | | | | | | | | | | | | | |
|  | 8e. List of Commercial Supporters (Add lines as needed) | | | Name of commercial supporter | | | | | Anticipated amount of commercial support | | | In-kind[[4]](#footnote-4) | | |
|  | Example: XYZ Pharma Company | | | | | $5,000 | | | No | | |
|  | Example: ABC Medical Device Company | | | | |  | | | Yes | | |
|  |  | | | | |  | | |  | | |
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| 8f. | Do you plan to have exhibits and/or displays?[[5]](#footnote-5) | | | | | |
|  |  | Yes (complete 8g) | |  | No (skip 8g) | |
|  | 8g. List of Exhibits and/or Displays (Add lines as needed) | | Name of Exhibitor | | | Display Fee |
|  | Example: XYZ Pharma Company | | | $500 |
|  |  | | |  |
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| 9. | Number of *AMA PRA Category 1 Credits*™ Requested:[[6]](#footnote-6) | | | | | | |  | | | | | | | | | | | |
| 10. | Target Audience | | | | | | | | | | | | | | | | | | |
|  | 10a. Which members of the healthcare team is this activity designed for?[[7]](#footnote-7) | | | | | | | | | | | | | | | | | | |
|  |  | Physicians | | |  | | | | Nurses | | | | | |  | | Pharmacists | | |
|  |  | Other: | | |  | | | | | | | | | | | | | | |
|  | 10b. Who is the target audience for this activity? (Select one) | | | | | | | | | | | | | | | | | | |
|  |  | Multi-specialty | | |  | | | | General Surgery | | | | | |  | | Surgical Subspecialities | | |
|  |  | Internal Medicine | | |  | | | | Medical Specialties | | | | | |  | | Family Medicine | | |
|  |  | OB/GYN | | |  | | | | Pediatrics | | | | | |  | | Radiology | | |
|  |  | Pathology | | |  | | | | Anesthesiology | | | | | |  | | Orthopaedic Surgery | | |
|  |  | Neurology | | |  | | | | Research | | | | | |  | | Oncology | | |
|  |  | Emergency Medicine | | |  | | | | Cardiology | | | | | |  | | Psychiatry | | |
|  |  | Other (describe): | | |  | | | | | | | | | | | | | | |
|  | 10c. Are there any attendance restrictions on this activity? | | | | | | | | | | | | | | | | | | |
|  |  | | Yes (complete 10d) | | | | | | |  | | | No (skip 10d) | | | | | | |
|  | 10d. What are the attendance restrictions for this activity? (e.g. Cardiologists only or LMNO Hospital Staff only) | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
| 11. | Educational Format | | | | | | | | | | | | | | | | | | |
|  | 11a. What is the educational format for this activity?[[8]](#footnote-8) (Select all that apply) | | | | | | | | | | | | | | | | | | |
|  |  | Lecture / Presentation | | |  | | | | Q & A Session | | | | | |  | | Panel Discussion | | |
|  |  | Case Study / Case Presentation | | |  | | | | Group Discussion | | | | | |  | | Journal Club | | |
|  |  | Morbidity & Mortality | | |  | | | | Hands-on (Skills Lab) | | | | | |  | | Demonstration | | |
|  |  | Simulation[[9]](#footnote-9) | | |  | | | | Patient Simulation[[10]](#footnote-10) | | | | | |  | | Problem Solving | | |
|  |  | Games | | |  | | | | Role Playing | | | | | |  | | Brainstorming | | |
|  |  | Self-directed Learning | | |  | | | | Role Modeling / Mentoring | | | | | |  | |  | | |
|  |  | Other (describe): | | |  | | | | | | | | | | | | | | |
|  | 11b. Why is this format appropriate for the setting, objectives and desired results of this activity? (maximum 25 words) | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
| 12. | Practice Gap[[11]](#footnote-11) | | | | | | | | | | | | | | | | | | |
|  | What is the professional practice gap this activity will address? What is the current practice compared to the best practice? (maximum 100 words)Supporting documentation must be attached. | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
| 13. | Educational Need(s)[[12]](#footnote-12) | | | | | | | | | | | | | | | | | | |
|  | 13a. State the educational need(s) that you determined to be the cause of the professional practice gap(s) (maximum 50 words each). | | | | | | Knowledge need **and/or** | | | | |  | | | | | | | |
| Skills/Strategy need **and/or** | | | | |  | | | | | | | |
| Performance need **and/or** | | | | |  | | | | | | | |
|  | 13b. Method(s) Used to Identify Educational Need(s) for the Activity.[[13]](#footnote-13)Supporting documentation must be attached. | | | | | | | | | | | | | | | | | | |
|  |  | Survey of Target Audience | | |  | | | | Peer Review Activity | | | | | |  | | Faculty Perception | | |
|  |  | Patient Care Audit | | |  | | | | Request from Experts | | | | | |  | | Mortality / Morbidity Statistics | | |
|  |  | Self Assessment | | |  | | | | Health Statistics | | | | | |  | |  | | |
|  |  | Other (describe): | | |  | | | | | | | | | | | | | | |
|  | 13c. Explain how this activity matches the healthcare team’s current or potential scope of professional activities. (maximum 25 words) | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
| 14. | Educational Objectives[[14]](#footnote-14) | | | | | | | | | | | | | | | | | | |
|  | 14a. Complete the following: Upon completion of this activity, learners will be able to… | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
|  | 14b. This activity is designed to change: (Select all that apply) | | |  | | Skills/Strategy | | | | |  | | | Performance | |  | | | Patient Outcomes |
|  | 14c. What are the desirable attributes of the target audience (i.e. competencies) associated with this activity?(Select all that apply)[[15]](#footnote-15) | | | | | | | | | | | | | | | | | | |
|  | ABMS/ACGME | | | | Institute of Medicine | | | | | | | | | | Interprofessional Education Collaborative | | | | |
|  |  | Patient Care & Procedural Skills | | |  | | | | Provide patient-centered care | | | | | |  | | Values/Ethics for Interprofessional Practice | | |
|  |  | Medical Knowledge | | |  | | | | Work in interdisciplinary teams | | | | | |  | | Roles / Responsibilities | | |
|  |  | Practice-based Learning and Improvement | | |  | | | | Employ evidence-based practice | | | | | |  | | Interprofessional Communication | | |
|  |  | Interpersonal and Communication Skills | | |  | | | | Apply quality improvement | | | | | |  | | Teams and Teamwork | | |
|  |  | Professionalism | | |  | | | | Utilize informatics | | | | | |  | |  | | |
|  |  | Systems-based Practice | | |  | | | |  | | | | | |  | |  | | |
|  |  | Other:  (list source and desirable physician attribute) | | |  | | | | | | | | | | | | | | |
| 15. | Outcomes Assessment[[16]](#footnote-16) | | | | | | | | | | | | | | | | | | |
|  | When and how do you plan to assess or measure changes in learner behavior and/or patient outcome data as they relate to the practice gap identified in question 12? The results of this assessment/measurement must be submitted to the CE Office. | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |
| 16. | Disclosure and Conflict of Interest Resolution[[17]](#footnote-17) | | | | | | | | | | | | | | | | | | |
|  | All individuals who are in a position to control the content of the activity must complete a disclosure form. If an individual has not completed a disclosure form in the past 12 months, the CE Office will request one from them via email. | | | | | | | | | | | | | | | | | | |
|  | 16a. Conference Planning Committee (Committee should include a WMed representative. Add lines as needed) | | | | | | | | | | | | | | | | | | |
|  | Name | | | | | | Email | | | | | | | | | | | Degree | |
|  | *Example: John Smith* | | | | | | [*jsmith@email.email*](mailto:jsmith@email.email) | | | | | | | | | | | *MD* | |
|  | *Example: Jane Jones* | | | | | | [*jones@med.med*](mailto:jones@med.med) | | | | | | | | | | | *NA* | |
|  |  | | | | | |  | | | | | | | | | | |  | |

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| --- | --- | --- | --- |
|  | 16b. Speaker(s) (Add lines as needed) | | |
|  | Name | Email | Degree |
|  | *Example: John Smith* | [*jsmith@email.email*](mailto:jsmith@email.email) | *MD* |
|  | *Example: Jane Jones* | [*jones@med.med*](mailto:jones@med.med) | *NA* |
|  |  |  |  |

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|  | 16c. Other(s)[[18]](#footnote-18) (Add lines as needed) | | |
|  | Name & Role | Email | Degree |
|  | *Example: John Smith, administrative assistant* | [*jsmith@email.email*](mailto:jsmith@email.email) |  |
|  | *Example: Jane Jones, abstract reviewer* | [*jones@med.med*](mailto:jones@med.med) |  |
|  |  |  |  |

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| 17. | Do you want this activity to appear on the WMed Calendar of CE Activities? | | | | | | | | | | | | | | | |
|  |  | Yes (complete 17a & 17b) | | | | | | | |  | No (skip 17a & 17b) | | | | | | |
|  | 17a. | Name of Contact Person | | | |  | | | | | | | | | | |
|  | 17b. | Phone Number of Contact Person | | | |  | | | | | | | | | | |
| 18. | Do you want to use the WMed online post-test module in addition to the standard (required) WMed CE evaluation form?Note: The WMed online post-test module provides pass/fail results only. It cannot be used to assess improvement on specific questions. All attendees will be required to complete the post-test in order to receive credit. | | | | | | | | | | | | | | | |
|  |  | Yes | | | | | | | |  | No | | | | | | |
|  | If yes is selected, test questions and answers must be emailed to [ce@med.wmich.edu](mailto:ce@med.wmich.edu) a minimum of two (2) weeks prior to the activity. | | | | | | | | | | | | | | | |
| 19. | Do you want online pre-registration to be available for this activity? Additional fees may be charged for this service. | | | | | | | | | | | | | | | |
|  |  | Yes | | | | | | | |  | No | | | | | | |
| 20. | Do you wish to use the CE Office Conference Planning Services? Additional fees may be charged for this service. | | | | | | | | | | | | | | | |
|  |  | Yes | | | | | | | |  | No | | | | | | |
| 21. | Is a draft of the brochure or other promotional materials attached?[[19]](#footnote-19) | | | | | | | | | | | | | | | |
|  |  | Yes | | | | | | | |  | No, draft is pending | | | | | | |
|  | **All promotional materials must be approved by the CE Office. Credit may be revoked if a draft is not received.** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Providing Organization | | | | | | | | | | | | | | | | |
| Organization Name | | | |  | | | | | | | | | | | | |
| Department(Required for WMed) | | | |  | | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | | |
| City | | | |  | | | | | State | | |  | | Zip Code | |  |
| Telephone | | | |  | | | | | Fax | | |  | | | | |
|  | | | | | | | | | | | | | | | | |
| Activity Director | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | | | |
| Email Address: | | | |  | | | | | | Phone: | | |  | | | |
| Company: | | | |  | | | | | | | | | | | | |
| Job Title: | | | |  | | | | | | | | | | | | |
|  | | | This date is my electronic signature indicating that I have read and agree to the policies, procedures, requirements, and commercial support policies in this application. I understand that the CE Office assumes no financial liability for the proposed activity. I recognize that follow-up surveys will be done to determine the efficacy of this activity. I will provide the CE Office with follow-up data as required. | | | | | | | | | | | | | |
| Date | | |
|  | | | | | | | | | | | | | | | | |
| Activity Coordinator | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | | | |
| Email Address: | | | |  | | | | | | Phone: | | |  | | | |
| Company: | | | |  | | | | | | | | | | | | |
| Job Title: | | | |  | | | | | | | | | | | | |
|  | | | This date is my electronic signature indicating that I have read and agree to the policies, procedures, requirements, and commercial support policies in this application. I understand that the CE Office assumes no financial liability for the proposed activity. I recognize that follow-up surveys will be done to determine the efficacy of this activity. I will provide the CE Office with follow-up data as required. | | | | | | | | | | | | | |
| Date | | |
|  | | | | | | | | | | | | | | | | |
| Primary Contact | | | | | | | | | | | | | | | | |
| Who should the CE Office communicate with? | | | | | | | | | | | | | | | | |
|  | | | |  | Activity Director | |  | Activity Coordinator | | | | | | |  | Other |
| If “Other” was selected, please provide the following information: | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | | | |
| Email Address: | | | |  | | | | | | | | | | | | |
| Phone Number: | | | |  | | | | | | | | | | | | |
| Company: | | | |  | | | | | | | | | | | | |
| Job Title: | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |

**CE Office Use Only**

Date Received: Initials: Application Fee: $175 $250 Waived

More Info Requested: Check Received: Check #

Date Approved: Initials:

Date Denied: Initials:

1. See pages 6-8 of policies for definitions. [↑](#footnote-ref-1)
2. See page 8 of policies for application fee schedule. [↑](#footnote-ref-2)
3. See pages 5 and 8-10 of policies for definitions. [↑](#footnote-ref-3)
4. See page 5 of policies for definitions. [↑](#footnote-ref-4)
5. See pages 5 and 10 of policies for definitions. [↑](#footnote-ref-5)
6. See page 10 of policies for how to calculate the number of hours. [↑](#footnote-ref-6)
7. Please include representatives of each profession in your planning committee. [↑](#footnote-ref-7)
8. See pages 11-12 of policies for definitions. [↑](#footnote-ref-8)
9. Activities using the WMed Simulation Center should complete an Application for a New Simulation Activity. [↑](#footnote-ref-9)
10. Activities using the WMed Simulation Center should complete an Application for a New Simulation Activity. [↑](#footnote-ref-10)
11. See pages 12-13 of policies for definitions. See Appendix 1 for a detailed explanation. [↑](#footnote-ref-11)
12. See Appendix 1 for a detailed explanation [↑](#footnote-ref-12)
13. See pages 13-14 of policies for definitions. [↑](#footnote-ref-13)
14. See page 14 of policies for definitions. [↑](#footnote-ref-14)
15. See Appendix 2 for detailed explanations of the different Desirable Physician Attributes. [↑](#footnote-ref-15)
16. See Appendix 1 for a detailed explanation of gaps, needs, objectives, and outcomes. [↑](#footnote-ref-16)
17. See pages 15-16 of policies for definitions. See Appendix 3 for a detailed explanation of the disclosure and conflict of interest resolution process. [↑](#footnote-ref-17)
18. See page 16 of policies for definitions. [↑](#footnote-ref-18)
19. See pages 17-18 of policies for guidelines. [↑](#footnote-ref-19)