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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 |
|  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| 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* | *MD* |
|  | *Example: Jane Jones* | *jones@med.med* | *NA* |
|  |  |  |  |

|  |  |
| --- | --- |
|  | 16b. Speaker(s)(Add lines as needed) |
|  | Name  | Email | Degree |
|  | *Example: John Smith* | *jsmith@email.email* | *MD* |
|  | *Example: Jane Jones* | *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* |  |
|  | *Example: Jane Jones, abstract reviewer* | *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 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)