

University of Florida College of Medicine
Continuing Medical Education Activity Application

GENERAL INFORMATION

1. Activity Information

- Title of activity: _____
- Date(s): _____
- Time(s): _____
- Location: _____
- # credits requested: _____
- UF College of Medicine Department/Division/Institute/Center: _____

2. Activity Director

- Name: _____
- Address: _____
- Phone: _____
- Email: _____

3. Activity Planning Committee (team members):

- _____
- _____
- _____
- _____

4. Administrative Contact

- Name: _____
- Address: _____
- Phone: _____
- Fax: _____
- Email: _____

5. Will this activity be receiving external support? Yes No

If yes, please check the correct box(es) describing the type of support:

- Commercial support (e.g. pharmaceutical or medical device company support): List companies and amounts: \$ _____
- Attendee registration fee (list amounts): \$ _____
- Exhibit fee (list amounts): \$ _____
- Other: _____

6. Is this a recurring activity? (Example: regularly-scheduled grand rounds, case conference, M&M conference, etc.)

- Yes No _____

7. If another organization is working with you on this activity, please list their name.

NEEDS ASSESSMENT

1. Identify the specific educational needs that will be addressed in this activity. Be as specific as possible. Information about disease prevalence, licensing or regulatory requirements, and data regarding practice performance of physicians is relevant here. Use additional pages as necessary.

2. ACCME requirements include needs assessment data that go beyond the planning committee's perception of need. Provide at least two different data sources establishing the educational need for the program that are beyond the activity director and planning committee's opinion. Be specific.

- Medical literature review (list) _____
- Research findings (describe) _____
- Clinical practice data (describe) _____
- Critical incidents (describe) _____
- Quality assurance studies (describe) _____
- Survey of potential participants (describe) _____
- Opinion of experts in specialty field(s) (identify) _____
- Mandate by regulatory authority (describe) _____
- Specific request by target audience (describe) _____
- Other: _____

PLANNING PROCESS (Use additional pages as necessary)
Please describe the process you used in developing this activity.

TARGET AUDIENCE
Please describe the audience for whom the activity is being planned.

EDUCATIONAL OBJECTIVES

1. Which of the following professional competencies does this activity address? (Check all that apply)

- Medical knowledge
- Patient care
- Interpersonal skills/communication
- Other
- Professionalism
- Practice-based learning and improvement
- Systems-based practice

2. As a result of participation in this activity, participants will be able to:

- a) _____
- b) _____
- c) _____

INSTRUCTIONAL FORMAT

Please select all of the instructional formats of the activity.

- Lecture
- Skills workshop
- Audience Response System to be used
- Other _____
- Case studies
- Small group discussion

EVALUATION

Indicate the evaluation method you plan to use.

- Standard CME evaluation form (sample provided by CME Office upon request)
- Other evaluation form (please attach sample)
- Group problem-solving exercises (please describe below or on separate page)
- Practice audits/chart reviews (please describe)
- Intent to change practice questionnaire (attach sample)
- Other _____

CONFLICT DISCLOSURE FORMS

Disclosure forms must be signed and submitted with this application. Forms must be completed by the **Activity Director**, each member of the **Planning Committee**, and each **Speaker**.

SIGNATURE

_____ Signature

Activity Director's Name (typed)

_____ Signature

Department Chair's Name (typed)

(To be completed by submitter)

APPLICATION SUBMISSION

The following items are required for approval:

- Planning process documentation
- Completed and signed application
- Needs assessment description and documentation of need
- Proposed agenda for activity
- Evaluation form (if applicable)
- Disclosure forms

Identify below the number of forms attached for each group:

_____ Planning committee members

_____ Activity Director

_____ Speakers

CME Office Use Only

Date received: _____ By: Mail Fax Hand delivery

Date sent to committee reviewers: _____

Gainesville CME Office:

Return to:

UF Gainesville CME Office
P.O. Box 100233
Gainesville, FL 32610-0233
Phone: 352-265-8081
Fax: 352-265-8082

Jacksonville CME Office:

Return to:

UF Jacksonville CME Office
2nd floor Faculty Clinic
653 West 8th Street
Jacksonville, FL 32209-6511
Phone: 904-244-3158
Fax: 904-244-3898
or email to: barbara.jones@jax.ufl.edu