

## Continuing Medical Education – MIMC Activity Request

**Instructions:** Please complete this form and return with an activity outline and all required documentation (bolded items in this form) to:

Mobile Infirmary Medical Center  
CME Coordinator/Education Department  
P.O. Box 2144, Mobile, AL 36652  
--or fax to 435-3072

Date Submitted: \_\_\_\_\_

### A. Proposed Activity

Activity Title: \_\_\_\_\_

Activity Type: **Either:**  Directly Sponsored -- or --  Jointly-Sponsored

**AND:**  Live-course  Live-series  Journal  Internet  Other: \_\_\_\_\_

Proposed Activity Dates: \_\_\_\_\_ Times: \_\_\_\_\_

Proposed Activity Location: \_\_\_\_\_

Number of *AMA PRA Category 1 Credit(s)*<sup>™</sup> requested: \_\_\_\_\_ Est. Attendance: \_\_\_\_\_

Target Audience: \_\_\_\_\_ Other groups activity will be open to: \_\_\_\_\_

**Activity (Physician) Director/Consultant:** \_\_\_\_\_

(involved in planning, organizing and conducting activity; attach additional sheet if multiple people involved)

Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**Activity Coordinator (if different from Director above):** \_\_\_\_\_

(responsible for paperwork-objectives, outline, rosters, arrangements, etc. of activity)

Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address/Department: \_\_\_\_\_ Fax: \_\_\_\_\_

Attach a list of *all* other individuals assisting with planning the activity. (**NOTE:** Each person in a position to control an education activity's planning, approval or content is **required** to complete and submit a "Disclosure & Attestation" form (see Appendix Exhibit D).

**Presenter:** (Note: Attach additional sheets if necessary for multiple speakers.)

Name of Speaker \_\_\_\_\_ Title: \_\_\_\_\_

Speaker Address \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Submit a curriculum vita for each speaker which validates expertise in the specified area. Each activity speaker **must** sign a "Disclosure & Attestation" form (see Appendix Exhibit D).

### B. Activity Funding

Please attach a separate activity budget. Check *all* of the following statements that apply:

Commercial Support **will not** be involved.  Fees will be collected (registration, meals, etc.)

\*Commercial Support **will** be involved.  Departmental/institutional funds

Name of Co.: \_\_\_\_\_

Other funding sources (specify): \_\_\_\_\_

\*Regarding the oversight of funds from a commercial supporter:

1. Funds received **must** be in the form of an educational grant payable to the accredited provider.
2. Terms, conditions, and purposes of the educational grant are documented in a signed Letter of Agreement between the provider and each supporter (see Appendix Exhibit E);
3. Honoraria and expenses are reasonable;
4. No other funds are paid by the proprietary company to the director of the activity, faculty, or others involved with the supported activity.

**C. Needs Assessment**

Statement of Need: *(Why do we need to have this activity? How will this improve patient care?*

What is the quality gap—or the professional practice gap—to be addressed? \_\_\_\_\_

Is it a gap in physician knowledge, competence and/or performance? \_\_\_\_\_

What are the potential or real barriers facing physicians if this need (gap) is to be addressed? \_\_\_\_\_

What is the activity designed to change (desired results)? \_\_\_\_\_

**D. Attach Educational Objectives**

What are desired results of the activity? (Objectives support the attainment of desired result.)

**Fill in the blanks: As a result of attending the activity, a participant will be able to \_\_\_\_, to \_\_\_\_, and to \_\_\_\_.** Avoid verbs like understand, appreciate, believe, know and learn as these are not measurable. Acceptable verb examples are discuss, describe, list, explain, summarize, assess, etc.)

What other groups within MIMC are you working with on this issue? \_\_\_\_\_

Which outside organizations are working on this issue that could be partnered with? \_\_\_\_\_

What ways could these groups help address or remove barriers identified in “needs assessment” above? \_\_\_\_\_

What other ways—aside from policy—can issue be addressed? \_\_\_\_\_

**E. Activity Content**

**Attach a copy of a proposed activity outline** (e.g. detailed outline of content to be presented or entire PowerPoint) designed to meet the objectives. Include exact times for each presentation or activity. What is the proposed format? **Check as many as apply.**

\_\_\_\_\_ Presentation      \_\_\_\_\_ Case Study      \_\_\_\_\_ Round Table      \_\_\_\_\_ Simulation  
 \_\_\_\_\_ Other (describe) \_\_\_\_\_

**F. Activity Evaluation**

Aside from presentation evaluation, what other types of evaluation method(s) will be used to know if the activity was effective at meeting the need and creating a change in competence, performance, or patient outcomes? (e.g. chart audits, increase in scores, etc.)

\_\_\_\_\_  
 Signature of Activity Director/Consultant

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Activity Coordinator

\_\_\_\_\_  
 Date

**CME/EDUCATION DEPARTMENT USE ONLY**

\_\_\_\_\_  
 Signature of Medical Education Committee Chair

\_\_\_\_\_  
 Date

Date Rec'd: \_\_\_\_\_ CME Committee Date: \_\_\_\_\_ Approved: \_\_\_\_\_ # Credits: \_\_\_\_\_ Deferred: \_\_\_\_\_

Disapproved: \_\_\_\_\_ Reasons: \_\_\_\_\_