



**OFFICE OF LIFELONG LEARNING
ENDURING MATERIALS CME CERTIFICATION
COURSE REQUEST FORM***

PLEASE TYPE

1. Program Information

Title of Program: _____

Expected Date of Release: _____

Supplemental Monograph/Study Guide to be Included: _____ Yes _____ No

Type of Activity:

- | | |
|---------------------|----------------------|
| _____ A. Videotape | _____ D. Journal |
| _____ B. Audiotape | _____ E. Internet |
| _____ C. Newsletter | _____ F. Other _____ |

Sponsoring Department: _____

2. Program Director

Name: _____
Department: _____
Address: _____
City/State/Zip: _____
Phone #: _____ FAX #: _____
Contact Name/Phone #: _____

3. Type of Program, please check one: _____ Meharry Medical College School of Medicine Sponsored Program
_____ Joint Sponsorship Program

4. Identify Joint Sponsor: _____

5. For joint sponsorship, indicate MMC School of Medicine Faculty Representative:

_____ Same as Program Director

Name: _____
Address: _____
City/State: _____
Telephone #: _____ FAX #: _____

6. Needs Assessment:

A. Please identify the educational needs of the target audience.

B. Please indicate how the needs were established. ACCME requires that you attach representative documents of how needs were determined. You must designate one of the following besides faculty perception (if used).

- | | | |
|-----------------------------|------------------------------------|----------------------------------|
| ___ Survey | ___ Self-Assessment | ___ Peer Review |
| ___ Patient Care Audit | ___ Faculty Perception | ___ Quality Assurance |
| ___ Consensus of Experts | ___ Mortality/Morbidity Statistics | ___ Prior Conference Evaluations |
| ___ Other Method (specify): | | |

C. Please provide a brief narrative of how you, along with a group of experts, used the above methods to assess the educational needs. Document by planning minutes, transcripts of discussions, etc. (i.e. frequently from a steering/planning committee's actions).

7. Although not directly measurable, state the broad purpose of the program. Please state the overall goal for the program:
8. Educational Objectives: Unlike overall goals, educational objectives should be measurable. Objectives typically address specific changes in the broad areas of knowledge, skills, and/or attitudes. Please state the specific objectives that the registrant should have accomplished after attending this course. Be sure that the objectives are derived from the program's goal. Use action verbs (e.g. "Participants should be able to identify, describe, diagnose, demonstrate, distinguish, manage, evaluate", etc.

At the conclusion of this course, the participant should be able to:

- (1)
- (2)
- (3)
- (4)

9. Statement of Program Content: Attach a copy of proposed program narrative, rough draft of journal, etc.
10. Faculty Involved in Presentation: Attach a copy of all faculty contributing to this enduring material listing complete name, title, department, and institutional affiliation.

11. Target Audience: MDs _____ Others: _____

Please specify physician specialties and Others:

12. Evaluation: The program will be evaluated by a questionnaire developed by the CME Office. Please indicate if you plan to use additional evaluation methods:
- | | |
|--|-------------------------|
| _____ Pre-Test | _____ Skills Assessment |
| _____ Post Test | _____ Interviews |
| _____ Written Questionnaire | |
| _____ No additional evaluation methods | |

13. Post-Test: All enduring materials must be accompanied by a post test to receive CME Credit. Please briefly explain the type of examination that will be used for this project, and required level of competency to "pass".

14. Commercial Support: Please indicate if this program will receive financial support from outside pharmaceutical companies and/or vendors. Programs must abide by the Standards for Commercial Support of Continuing Medical Education. Contributing Faculty will be sent a Disclosure Policy and asked to complete the Disclosure Declaration.

_____ Yes _____ No

Please attach a list of possible commercial support contributors.

Signature: Program Director

Signature: Department Chairperson, if appropriate

Date Submitted: _____

***THE COURSE REQUEST FORM MUST BE COMPLETED AND RETURNED TO THE OFFICE OF LIFELONG LEARNING BEFORE ANY ARRANGEMENTS ARE MADE. A COPY OF THE REQUEST WILL BE RETURNED AFTER REVIEW AND APPROVAL OF THE PROGRAM BY THE CME COMMITTEE. THE FINAL GALLEY PROOFS OF BROCHURES, SYLLABI AND/OR WRITTEN MATERIALS MUST BE APPROVED BY THE OFFICE OF LIFELONG LEARNING BEFORE PRINTING.**

CME Clinical Advisory Board:

_____ Approved

_____ Not Approved

Signature

Date

___ APPROVED FOR AMA/PRA CATEGORY 1:

Number of Hours Approved:

APPROVED FOR:

- _____ 1 year from date of release
- _____ 2 years from date of release
- _____ 3 years from date of release

___ NOT APPROVED DUE TO:

- ___ Insufficient planning involvement by the CME Office
- ___ Insufficient time before program presentation
- ___ Needs assessment insufficient
- ___ Education objectives lacking, insufficient or inappropriate
- ___ Non-compliance with Standards for Commercial Support of CME
- ___ Non-compliance with Disclosure Statement for CME
- ___ Other

___ INCOMPLETE APPLICATION:

- ___ Proposed program incomplete
- ___ Evaluation instrument insufficient
- ___ Program printed without galley proof review
- ___ Program not within definition of CME

___ Approved for ___ hours AMA/PRA Category 2 credit

Clinical Reviewer

CME Clinical Advisory Board

Date

Renee Ewing Bowen, RN, JD.

Associate Dean for Continuing Medical Education

Director, Office of Lifelong Learning

Date

PLEASE RETURN COMPLETED FORM TO:

The Office of Lifelong Learning
Meharry Medical College
1005 Dr. D.T. Todd Blvd.
Nashville, TN 37208

FOR OCME USE ONLY

Program Number: _____ (to be assigned after approval)