

**MOUNT CARMEL  
REQUEST FOR CATEGORY 1 CERTIFICATION  
ACTIVITY PLANNING FORM**

***DIRECTIONS FOR COMPLETING THIS FORM:***

**Requests are due at least 60 days prior to the activity. Physician planners or a representative of the CME Committee must present the application to the committee. The committee meets the second Thursday of the month at 5:30 p.m., rotating between MCW and MCE. (Please visit "CME Committee Meeting Schedule.") You will be notified in writing of the CME Committee's action.**

***PLEASE ATTACH THE FOLLOWING:***

- Complete conference agenda listing starting and ending times (if more than 1 hr)
- Topics, speakers, objectives for *each* speaker
- List of speakers with affiliation(s) and curriculum vitae(s) for non-Mount Carmel speakers
- NEW**  Outline of all speakers' lectures for peer review (prior to activity)

Date of Request \_\_\_\_\_ Category 1 Credits Sought \_\_\_\_\_  
(Attach agenda if more than 1 hour sought)

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

Speaker(s) Name, Position, and Affiliation (Use additional pages if necessary): \_\_\_\_\_

**(If speaker(s) is a non-Mount Carmel physician (s), please attach CV(s) )**

Activity Date \_\_\_\_\_ Location \_\_\_\_\_ Time \_\_\_\_\_

Lead Physician Planner \_\_\_\_\_ Dept. \_\_\_\_\_  
Planning Committee members \_\_\_\_\_

**1. NEEDS ASSESSMENT**

***NEW REQUIREMENT: PLANNERS MUST provide documentation of at least one evidence-based reference (to the extent possible) as a form of needs assessment. Evidence-based references refer to the best available evidence from the literature accepted within the profession of medicine. This is the minimum standard. Where applicable, regulatory agency requirements may serve as evidence-based reference. In addition, at least one other form of needs assessment is required.***

**I. REQUIRED: one of the following must be present (to the extent possible) to support educational need**  
 Current evidence-based reference (list journal, article title, and date published) \_\_\_\_\_

Regulatory agency requirements (*describe and attach supporting documentation*) \_\_\_\_\_

ACGME General Competencies – patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice (*identify competency to be addressed*) \_\_\_\_\_

Institute of Medicine's 5 core competencies – provide patient centered care, work in interdisciplinary teams, employ evidence-based practice, apply quality improvement and utilize informatics (*identify competency to be addressed*) \_\_\_\_\_

**II. At least one additional form of needs assessment is REQUIRED. Please indicate all that apply:**

Currently accepted consensus statements or guidelines (*list source*) \_\_\_\_\_

Health statistics of hospital (e.g., Morbidity and Mortality) (*attach examples*) \_\_\_\_\_

Performance or Process Improvement Studies, QA Studies/medical audits (*attach/reports/minutes*) \_\_\_\_\_

Medical staff input/internally identified problem (*attach department minutes/correspondence*) \_\_\_\_\_

New medical information: advances in treatment modalities, diagnostic methods, procedures or equipment

**Describe:** \_\_\_\_\_

Other (*be specific and attach supporting documentation*) \_\_\_\_\_

## 2. TARGET AUDIENCE & ESTIMATED ATTENDANCE

**Target Audience: Please check the line(s) next to members of the target audience:**

Anesthesiologists                       Cardio/Thoracic Surg.                       Extended audience (specify):  
 Family Practitioners - (60 day approval)     Internists    \_\_\_\_\_  
 Obstetricians/Gynecologists                       Orthopaedic Surgeons                                      \_\_\_\_\_  
 Psychiatrists     Surgeons    \_\_\_\_\_

**Estimated Attendance: Please write the number of estimated attendees for each category:**

Mount Carmel physicians \_\_\_\_\_ Non-Mount Carmel physicians \_\_\_\_\_  
MC nurses \_\_\_\_\_ Non MC nurses \_\_\_\_\_ Other \_\_\_\_\_

List any special **background requirements** of the prospective participants (for procedural/skills course, the trainees must have background knowledge, basic skills, and clinical experience relevant to the tasks to be learned).

\_\_\_\_\_  
\_\_\_\_\_

## 3. CONFERENCE GOAL/COURSE DESCRIPTION

Please describe the purpose and overall goal of the series or course, including the format.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 4. LEARNER OBJECTIVES

Specific educational objectives should be written for each particular subject or topic. They are a statement of what the *LEARNER* should expect to have accomplished at the conclusion of the learning activity. Please see "How to Write Learning Objectives" for writing assistance and then please list objectives for each speaker below:

The participant should be able to:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How do these objectives relate to the needs described earlier? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## 5. INSTRUCTIONAL METHODS/COURSE DESIGN

Please select the method of instruction/course design:

Lecture     Workshop/Symposium     Hands on Course     Other \_\_\_\_\_  
 New Procedures and Skills Training Course (Select if this course develops special procedural skills)

**If the proposed activity is an enduring material, please indicate the type and describe:**

Written Monograph     CDROM     Intranet Activity (Mount Carmel Intranet)

Please describe: \_\_\_\_\_  
\_\_\_\_\_

## 6. PUBLICITY

Please indicate how you would like the proposed activity to be publicized:

teaser postcard     brochure     flyer only     Other (please describe) \_\_\_\_\_  
\_\_\_\_\_

To whom would you recommend this activity be publicized? (local, regional, etc...)

\_\_\_\_\_

**7. INSTRUCTIONAL MATERIALS**

What instructional materials will be made available to participants?

**8. METHOD OF EVALUATION**

How will the effectiveness of this activity be assessed in meeting the objectives listed previously?

**9. AUDIO/VISUAL MATERIALS**

Indicate the equipment needed for the CME activity:

- Slides
- Medical publications
- Audiotapes/Videotapes
- LCD for PowerPoint presentation
- Computer for PowerPoint presentation
- Other: \_\_\_\_\_

**10. REQUEST FOR AUDIO OR VIDEOTAPING** (Expense must be included in budget below)

*All symposia lectures will be audio taped. Recording of regularly-scheduled conferences is by special request and approval.*

Audio tape                       Videotaping

Reason needed \_\_\_\_\_

**11. PROPOSED ACTIVITY BUDGET**

Please provide an estimated budget for the proposed CME activity.

<u><b>EXPENSES</b></u>		<u><b>INCOME/ SUPPORT</b></u>	
Honoraria	\$ _____	Registration Fees	\$ _____
Travel/Hotel	\$ _____	Educational Grant/s	(be specific if fees vary between attendees) <u>Amount</u> <u>Company Name</u>
Publicity	\$ _____		\$ _____
Dietary	\$ _____		\$ _____
Miscellaneous	\$ _____		\$ _____
(Please explain)			\$ _____
		Exhibit Fee/s	\$ _____
			\$ _____
			\$ _____
			\$ _____
			\$ _____
		Other Support	\$ _____
<b>Total Expenses</b>	<b>\$ _____</b>	<b>Total anticipated Support:</b>	<b>\$ _____</b>

**Subsidy requested from  
CME Operations Budget  
\$**



Please obtain *only one administrative signature* based on the following (See A & B):

**A) Obtain Department Chairman's approval for activities involving one department.**

**DEPARTMENT CHAIRMAN RECOMMENDATIONS AND APPROVAL**

I agree with the needs assessment, target audience, conference goal, objectives, instructional methods, publicity, and budget and assure departmental support of the proposed activity.

\_\_\_\_\_  
Chairman's Signature

\_\_\_\_\_  
Date

**OR**

**B) Obtain CDC approval for activities involving 2 or more clinical departments or addressed to the needs of the staff in general.**

**CLINICAL DEPARTMENT COUNCIL RECOMMENDATIONS AND APPROVAL**

I agree with the concept and planning and endorse the medical staff's support of this activity.

\_\_\_\_\_  
Chairman's Signature

\_\_\_\_\_  
Date

**MEDICAL EDUCATION APPROVAL**

This activity has been reviewed and meets the Essentials and Standards for Commercial Support and is ready to be presented to the CME Committee for approval.

\_\_\_\_\_  
CME Manager's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CME Committee Chair's Signature

\_\_\_\_\_  
Date