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**Leah Romito, MD, Chair Medical Education Committee**

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1/15

**APPLICATION TO CCHS FOR CME CREDIT – AAFP Prescribed Credit**

**\*\* Priority Items to complete**

Please allow 6 weeks for AAFP to process applications.

1. Please send completed applications at least six weeks before planned events (if possible) to both Norma Romero-Wills (CME Coordinator) and Leah Romito MD (CME Chair).
2. We will need at least 2 weeks to review and submit a completed application.
3. Payments (see amount on last page) will need to be secured by applicant. Payment **must** be received before the accreditation review process can begin
   1. Checks can be made to AAFP
   2. Credit card information can be given to Norma Romero-Wills
   3. Org # within CCHS (for L3) can be supplied to Norma

**Please allow 6 wks. For AAFP to process applications – but once submitted, CME pending credits can be given (with hopes that application with be accepted).**

**\*\*Date submitted to CME Dept at CCHS \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Step 1 of 6: Activity Type**

\*\*Select activity type: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If this activity will be repeated multiple locations and/or dates within a one-year period, number of time offered?  (estimate if unknown)

**Choices: Live Activity – Single Time in one year**

**Live Activity – Multiple Times in one year**

**Case Conference (e.g. Cancer Conference, Psychiatry Case Conference)**

**Regularly Scheduled Series (e.g. Noon Conference)**

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

**\*\*Activity Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If Live Activity offered at multiple locations or multiple dates over the year, # of times offered:**

**If Regularly Scheduled Series that occur at one location or institution over 1 year, # courses in series:**

For series, first date required with original application. Submit subsequent dates (updates) monthly or quarterly through out the year.

**INDICATE NUMBER OF AAFP CME CREDITS REQUESTED \*\*Total credits requested \_\_\_\_ Prescribed**

**(if recurrent, indicate how much credits per course)**

**Step 2 of 6: Additional Information**

**The activity director attests that this activity complies with the and that the activity meets every requirement of the *Standards*, whether or not this activity is being supported with commercial funding.**

**Activity Director’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Activity Director’s Title: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all commercial supporter(s):  or None

Physician involved with CME who may attest this is appropriate for FPs: Leah Romito MD, Director of CME.

**Step 3 of 6: Activity Details**

The following information must be submitted for the CME activity to be reviewed for AAFP CME credit.

**Supporting materials:**

* If brochure is available, please submit.
* Need evaluation form. If none is available, can use generic one from Professional Development.

The text fields below are expandable.

\*\*1. What methods were used to determine the **need** for this CME activity (Check all that apply)?

Survey results of potential learners  Evaluations from previous CME Activities

Needed Health Outcomes  Identified New Skills  Literature Review

Quality Improvement (QI) Data  Federal/State Government Mandate  Other:

\*\*2. What is your activity designed to change (Check all that apply)?

**Knowledge: Participants should be able to recall information learned in the CME Activity**

**Competence: Participants should be able to show in an educational setting how to do what the CME activity intended them to be able to do (example: Procedure courses)**

**Performance: Participants should integrate what the CME activity intended them to be able to do into their practices (Provider must have mechanism of capturing this data from learners following the CME Activity**

**Patient outcomes: The health status of patients should improve due to changes in the practice behavior of participants (Provider must have mechanism of capturing patient-level data from learners following the CME Activity**

\*\*3. Statement of purpose: Provide a short description of the activity for our application reviewers:

\*\*4. List specific **learning objectives** using medical terminology to describe what the learner can expect to know or do after the activity. Clear details about the learning objectives and intent of each topic will streamline the review and approval process. This is of particular importance if topic titles are not self-explanatory:

\*\*5. List the **faculty** of the activity, including titles and degrees. Do not provide a CV:

\*\*6. List **principal audience** (professional groups for whom the activity has been designed):

\*\*7. Describe **activity evaluation method** and how the evaluation results will be used. (**A sample copy of the evaluation form must be included**.)

**Step 4 of 6: Session Details**

\*\*1a. **For a single or multi date/location activity, submit an hour-for-hour agenda (include start time, end time, breaks, and title and speakers’ name for each topic). For multi-date/location activities, please also include the location and date of each session.**

1b. For a **series activity only (ex: hospital grand rounds)**, please list each session title, date, beginning/end time, speaker, number of requested credits, and learning objectives.

\*\*2. **Location/Date** of activity (attach separate page for multiple locations):

Date(s)

Facility name

Street

City/State  Zip Code

\*\*3. What are the **core competencies** this activity is designed to address (Check all that apply)?

Interpersonal and communications skills Medical knowledge Patient care Practice-based learning and improvement

Professionalism Systems-based practice

\*\*4. Primary **teaching methods** (Check all that apply):

Lecture Panel discussion Question and answer Hands-on workshop

Round table discussionCase presentation Other:

**Step 5 of 6:**

Do you want this activity to appear at AAFP.org?  Yes  No

If yes, include any URL to find out more information about your activity

If yes, include a Marketing Description (max 500 characters) to learn more about the value of registering and/or participating in the CME that you offer. The first 160 characters of the marketing description will appear in the search listing.

**Step 6 of 6: Payment Information**

1) Org number for L3 \_\_\_\_\_\_\_\_\_\_ Staff who has approved this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2) Checks – made out to AAFP

3) Credit card/Check #  Type of credit card  Exp. date  Amount $

Name on card  If you would like a faxed receipt, please provide fax number:

|  |  |
| --- | --- |
| **LIVE** | **FEE** |
| Single Live activity up to 8.00 credits | $295.00 |
| Single Live activity over 8.00 credits | $395.00 |
| All other Live activities  *(includes annual series, multi-site within 1 year)* | $595.00 |

**FOR CME DEPT USE ONLY**

Approved by Chair Leah Romito, MD or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Approval for \_\_\_\_\_\_\_\_\_\_ Prescribed credits

Funding secured \_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not approved by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Additional Needs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

Signature of Chair Medical Education Committee or Substitute \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Submitted to AAFP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**