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| **Provider Information**

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| **Responsible Organization:** |  |
| Mailing Address: |  |
|  |
|  |
| **Activity Director Name:** |  |
| Phone: |  | Email: |  |
| **Activity Administrator Name:** |  |
| Phone: |  | Email: |  |
| Website: |  |

**Activity Information**

|  |  |
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| Activity Title: |  |
| Activity Date(s): |  |
| Activity Location: |  |
| Number of CME hours requested: |  |
| This Activity is: |  | Directly Provided (UHMS Only) |  | Jointly Provided |
| Activity Type is: |  | Live Course |  | Journal-Based CME |  | Enduring Material (Online) |  |
| Activity occurrence is: |  | One time activity |  | Ongoing activity |

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| **X** | **Annual Application Fee** (Required for all applicants) | **$300 (Required for all applicants)** |
|  | **Introductory Course Annual Fee** (additional fee) | **$100 (if applicable)** |
|  | **Multiple Course Fee** (More than 1 activity held per year-additional fee) | **$200 (if applicable)** |
|  | **Total:**  | **$** (Multiply by # of years) | **= $** |
|  |  |  |  |

**\***Payment is due upon receipt of this application and is non-refundable. First time applicants may receive 1 year approval only while renewing organizations may request up to a 3 year approval. After completion of each CME activity, a closing report must be submitted with a charge of $25 per CME certificate sent out.

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| Card Number (All major cards accepted) | Expiration Date (mm/yyyy) | Security Code  |
|  |  |
| Card Holder Printed Name |  |
|  |  |
| Signature | Date |

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| **UHMS OFFICE USE ONLY**

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|  | Approved for |  | *AMA PRA Category 1 Credits™* |

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| --- | --- |
|  | Not Approved |

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| **Activity Approval Date** | **Activity Expiration Date** |
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|  |  |
| **Education Committee Chair Signature** | **Date** |

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**UHMS REQUIREMENTS FOR CME EDUCATIONAL ACTIVITIES**

Please read carefully these instructions in their entirety prior to completing the CME application and supporting documents. This will provide a guideline and tool to assist with completion. Complete all sections applicable for this activity and assemble all attachments as noted with the appropriate label.

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| **REQUIREMENTS FOR ALL EDUCATIONAL ACTIVITIES** |
| CME Application with Payment | **Activity information including payment with check or credit card information enclosed.** All payments should be sent to: UHMS, 631 US Highway 1, Suite 307, North Palm Beach, Florida, USA. Application documents should be submitted electronically to stacy@uhms.org  |
| Criterion 1:  | The UHMS CME Mission is: “The Continuing Medical Education mission of the Undersea and Hyperbaric Medical Society is to develop and promote evidence-based educational activities that improve the scientific knowledge, competence and/or performance within the scope of undersea and hyperbaric medicine, including wound healing. The primary aim is to improve health care delivery and quality of patient care in diving and hyperbaric medicine practice.  The target audience of this effort are physicians and allied health professionals, both nationally and internationally.” All direct and jointly provided educational activities should be planned and implemented to meet the UHMS CME Mission as UHMS is the responsible accredited provider of all activities reported to ACCME.  |
| Criterion 2-6: | The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners. Activities/educational interventions are required to be designed to change competence, performance, or patient outcomes as described in its mission statement (criterion 1). Educational format must be appropriate for the setting, objectives and desired results of the activity and the activity must be developed in the context of desirable physician attributes |
| Attachment 1 | Submit a copy of the **brochure or announcement** including all principal faculty, expected results (goals or objectives), target audience, Accreditation Statement, Designation Statement, Disclosure Statement, UHMS Disclaimer.**Accreditation Statement**: Jointly Provided: “This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Undersea and Hyperbaric Medical Society and (name of nonaccredited provider). The Undersea and Hyperbaric Medical Society is accredited by the ACCME to provide continuing medical education for physicians.”UHMS Directly Provided: “The Undersea and Hyperbaric Medical Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.”**Designation Statement:** “The Undersea and Hyperbaric Medical Society designates this [\*learning format] for a maximum of [number of credits] AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.”*(\*Learning format: live activity, enduring material, journal-based CME; AMA PRA Category 1 Credit(s)™ is required to be italicized whenever posted as it is an AMA trademark.)***Full Disclosure Statement:** “All faculty members and planners participating in continuing medical education activities sponsored by (name of responsible organization) are expected to disclose to the participants any relevant financial relationships with commercial interests. Full disclosure of faculty and planner relevant financial relationships will be made at the activity.”**UHMS Disclaimer:** “The information provided at this CME activity is for Continuing Medical Education purposes only. The lecture content, statements or opinions expressed however, do not necessarily represent those of the Undersea and Hyperbaric Medical Society (UHMS), its affiliates or its employees.” |
| Attachment 2-3 | Individuals in **Control of Content Disclosure to Participants and Resolution of Conflicts of Interest**. All individuals who are in control of content at any time must be listed with relevant financial relationships disclosed. List name of individual, their role (faculty, planner), name of commercial interest if (if applicable) and nature of relationship (if applicable). Program Director must sign/date and check the mechanism used to resolve all conflicts of interest prior to the start of the activity.  |
| Attachment 10 | **Schedule:** must include exact time of each presentation, topic and faculty member(s) with credentials for each time slot. CME hours are counted by each quarter hour (e.g. .25 is 15 minutes; .50 is 30 minutes; .75 is 45 minutes and 1.00 is 1 hour). CME hours are rounded to the nearest quarter hour. CME hours count only for any time that is participant to faculty interaction. Breaks, lunch and travel time are not included. **NOTE:** Introductory Training Courses only must complete a detailed hour-by-hour objective for each presentation within the schedule with the above listed requirements.  |
| Attachment 11 | **Individual Disclosure Form** **(CME Form 110)** signed by each individual in control of the content of the activity. This includes all faculty, planners, reviewers, authors, etc. All individual disclosure forms should be reviewed to complete Attachment 2: Individuals in Control of Content Disclosure to Participants |
| **ADDITIONAL REQUIREMENTS IF ACTIVITY IS COMMERCIALLY SUPPORTED**  |
| Attachment 7 | The **income and expense statement** for this activity that details the receipt and expenditure of all monies, including commercial support. |
| Attachment 8 | Each executed **commercial support agreement** for the activity designating the name of the commercial supporter, financial amount provided, in-kind item provided and signed by the commercial support provider, the Course Director and the UHMS CME Coordinator. A commercial interest is any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The ACCME does not consider providers of clinical service directly to patients to be commercial interests. |
| Attachment 9 | The commercial support disclosure information exactly **as it was provided to the learners** (program book, powerpoint slide) |
| **ADDITIONAL REQUIREMENTS FOR INTRODUCTORY TRAINING COURSE (live 40 Hour Course)** |
| Attachment 12 | **Brief CV/Resume** for each faculty member to ensure they are appropriately credentialed and trained to present their topic. |
| Attachment 13 | **UHMS Designated Introductory Training Course Schedule Checklist**: please list the page number each topic is found within the detailed hour-by-hour schedule with objectives listed under **Attachment 10.** |
| Attachment 14 | **Certificate of Attendance:** Must not state any CME hour statements and include only the participant name, course title, course date, hours it was approved for but may not designate the participant earning any hours. A CME certificate will be sent to all MD’s/DO’s to designate how many hours earned.  |

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| **UPON COMPLETION OF ACTIVITY THE FOLLOWING ATTACHMENTS MUST BE SUBMITTED** |
| Closing Report CME Form 105 | Complete the CME closing report form noting how many physician participants, non-physician participants and the number requiring a CME certificate. Also enclose check or credit card payment at $25/CME Certificate processed. CME Certificates are sent to MD’s/DO’s. Letters of attendance to non-physicians may also be requested at $25/Certificate. All payments should be sent to: UHMS, 631 US Highway 1, Suite 307, North Palm Beach, Florida, USA. Closing documents should be submitted electronically to stacy@uhms.org. |
| Attachment 4 | The disclosure information **as provided to learners** about relevant financial relationships (or absence of relevant financial relationships) that each individual in a position to control the content of CME disclosed to provider. (See attachment 2-3 General Disclosure) |
| Attachment 5 | The data or information generated form this activity about changes achieved in learners competence or performance or patient outcomes. Please submit a summary of participant evaluations reflecting what changes were achieved in relation to the identified practice gap(s).  |
| Attachment 6 | The ACCME accreditation statement for this activity, **as provided to learners (from program book, powerpoint slide, etc)** |
| Change in CME Form 106 | **Change in CME Form 106** to be submitted in advance noting changes to faculty, schedule, CME hours, location, date, Course Director, etc. This is to be submitted to the Education Committee Chair to approve prior to the course taking place. |

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| **Criterion 1: The provider has a CME mission statement that includes expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program.**  |
| **UHMS Mission Statement:** The Continuing Medical Education mission of the Undersea and Hyperbaric Medical Society is to develop and promote evidence-based educational activities that improve the scientific knowledge, competence and/or performance within the scope of undersea and hyperbaric medicine, including wound healing. The primary aim is to improve health care delivery and quality of patient care in diving and hyperbaric medicine practice.  The target audience of this effort are physicians and allied health professionals, both nationally and internationally.   ***CME Purpose***The primary purpose of the UHMS Physician CME program is to educate physicians in all disciplines, both nationally and internationally, with the principles and practices of undersea and/or hyperbaric medicine. The secondary purpose is to educate allied health professionals and medical administrators who have educational interests or needs in undersea or hyperbaric medicine. Ultimately, these activities should enhance health care delivery and quality of patient care. |

[ ]  **Please check the box indicating you understand and agree to plan your activity in accordance with the UHMS CME Mission as the responsible accredited provider.**

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| **Criterion 2: The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners.** |
| **State the professional practice gap(s)\* of your learners which the activity was based *\*(Practice Gaps are defined as "the difference between health care processes or outcomes observed in practice, and those potentially achievable on the basis of current professional knowledge.”)*** |
|  |
| **State the educational need(s) that you determined to be the cause of the professional practice gap(s)**  |
| **Knowledge Need** **and/or(Facts and information acquired by a person through experience or** **education)** |  |
| **Competence Need and/or****(Having the ability to apply knowledge, skills, or judgment in practice if** **called upon to do so)** |  |
| **Performance****(What a physician actually does in practice)** |  |

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| **Criterion 3: The provider generates activities/educational interventions that are designed to change competence, performance, or patient outcomes as described in its mission statement.** |
| **State what this CME activity was designed to change in terms of learners’ competence/performance/patient outcomes (recommend ~ 50 words)** |
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| **Criterion 5: The provider chooses educational formats for activities/interventions that are appropriate for the setting/objectives and desired results of the activity** |
| **Explain why this educational format is appropriate for this activity (recommend ~25 words)** |
|  |

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| **Criterion 6: Indicate the desirable physician attributes (i.e. competencies) this activity addresses:** |
| **ACGME/ABMS Competencies** | **Institute of Medicine Competencies** | **Interprofessional Education Collaborative Competencies** |
|  | Patient Care & Procedural Skills |  | Provide Patient-Centered Care |  | Values/Ethics for Interprofessional practice |
|  | Medical Knowledge |  | Work in Interdisciplinary Teams |  | Roles/Responsiblities |
|  | Practice-Based Learning & Improvement |  | Employ Evidence-Based Practice |  | Interprofessional Communication |
|  | Interpersonal & Communication Skills |  | Apply Quality Improvement |  | Teams & Teamwork |
|  | Professionalism |  | Utilize Informatics |  |  |
|  | Systems-Based Practice |  |  |  |  |

**ATTACHMENT 1: SAMPLE BROCHURE WITH REQUIRED STATEMENTS**

 Activity Title

Date/Location

|  |  |
| --- | --- |
| PRINCIPLE FACULTY:* John Smith, MD
* Jane Doe, RN
* Tom Sample. DO
 | WHO SHOULD ATTEND:* Physicians
* Nurses
* CHT/DMT/EMT
* Other Allied Health Professionals
 |

TOPICS:

* History of Hyperbaric Medicine
* Decompression Sickness
* Chamber Operations (Mono-place/Multi-place)
* Billing and Coding of Hyperbaric Medicine
* UHMS Approved Indications
* Ethics in Hyperbaric Medicine

**COURSE OBJECTIVES**: Participants should be able to describe the philosophies of the physics, physiology, pathophysiology and the medical aspects of compressing patients and observers within the hyperbaric environment ensuring safe treatment protocol. The learners will be able to recognize diving accidents and gain knowledge, performance and competence to safely and efficiently evaluate and medically treat divers, which in turn improves overall patient outcomes and decreases the professional practice gaps identified for this activity.

**Accreditation Statement**Jointly Provided: “This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Undersea and Hyperbaric Medical Society and (name of nonaccredited provider). The Undersea and Hyperbaric Medical Society is accredited by the ACCME to provide continuing medical education for physicians.”

UHMS Directly Provided Only: “The Undersea and Hyperbaric Medical Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.”

**Designation Statement:** The Undersea and Hyperbaric Medical Society designates this [\*learning format] for a maximum of [number of credits] AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**(\*Learning format:** live activity or enduring material; ***AMA PRA Category 1 Credit(s)™.*** Is required to be italicized whenever posted as it is an AMA trademark.)

**Full Disclosure Statement**All faculty members and planners participating in continuing medical education activities sponsored by (name of responsible organization) are expected to disclose to the participants any relevant financial relationships with commercial interests. Full disclosure of faculty and planner relevant financial relationships will be made at the activity.***UHMS Disclaimer***The information provided at this CME activity is for Continuing Medical Education purposes only. The lecture content, statements or opinions expressed however, do not necessarily represent those of the Undersea and Hyperbaric Medical Society (UHMS), its affiliates or its employees.

ATTACHMENTS 2-3: INDIVIDUALS IN CONTROL OF CONTENT DISCLOSURE TO PARTICIPANTS SAMPLE

**Activity Title**

**Activity Date/Location**

**All individuals in control of content for this educational activity with their relevant financial relationship disclosed are listed below. ACCME defines a relevant financial relationship “as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.” An individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a teacher, or an author of CME, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the CME activity.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual | Individuals Role in Activity | Name of Commercial Interest (If Applicable) | Nature of Relationship |
| John Smith, MD | Faculty/Planner/Author | None | ------- |
| Jane Smith, RN, CHT | Faculty/Planner/Author | Pharma Co USA | Research Grant |
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| Name of Commercial Supporter | Amount of Monetary Commercial Support | In-Kind (List what was provided) |
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Attachment 3: Please check the mechanism used below to identify and resolve all conflict of interest for all individuals in control of content prior to the start of the educational activity being delivered to the participants:

|  |  |  |  |
| --- | --- | --- | --- |
|  | No relevant relationship(s) to resolve |  | Provided talking points/outline |
|  | Restricted presentation to clinical data |  | Data, slides added or removed |
|  | Reassigned faculty’s lecture/topic |  | Reviewed content – free of commercial bias |
| Notes: |  |
|  |
| Signature of Activity Director/Coordinator |  | Date: |   |

ATTACHMENT 7: INCOME/EXPENSE STATEMENT (FOR AN INDIVIDUAL ACTIVITY) SAMPLE

|  |
| --- |
| **COURSE TITLE/COURSE DATE** |
| **INCOME** | **QTY** | **COST** | **SUBTOTAL** | **NOTES** |
| Physician Registration | 8 | $1,000 | $8,000 |  |
| Non-Physician Registration |  |  |  |  |
| Exhibitor Income |  |  |  |  |
| Advertising Income |  |  |  |  |
| \*Commercial Support (details of commercial supporter name, monetary amount or in-kind provided) |  |  |  |  |
|  |  |  |  |  |
| **TOTAL INCOME:**  |  |  |  |  |
|  |  |  |  |  |
| **EXPENSES** |  |  |  |  |
| Administrative Expense |  |  |  |  |
| Supplies |  |  |  |  |
| Food |  |  |  |  |
| Venue |  |  |  |  |
| CME application |  |  |  |  |
| CME Certificates ($25 each) |  |  |  |  |
| Shipping/Printing |  |  |  |  |
| Travel |  |  |  |  |
| Audio/Visual Equipment  |  |  |  |  |
| Faculty Honorarium |  |  |  |  |
| \*Commercial Support (must include name of commercial supporter, monetary amount or in-kind support provided and how the support was expended) |  |  |  |  |
|  |  |  |  |  |
| **TOTAL EXPENSES:**  |  |
|  |  |  |  |  |
| **NET REVENUE (Total Income-Total Expenses):** |  |  |  |  |
| \*The provider may not use commercial support to pay for travel, lodging, honoraria, or personal expenses for non-teacher or non-author participants of a CME activity. The provider may use commercial support to pay for travel, lodging, honoraria, or personal expenses for bona fide employees and volunteers of the provider, joint provider or educational partner |

ATTACHMENTS 8: UHMS COMMERCIAL SUPPORT AGREEMENT REQUIRED (IF APPLICABLE)

|  |  |  |
| --- | --- | --- |
|   | **Undersea and Hyperbaric Medical Society****Written Agreement For Commercial Support** | **LOA CME 202** |

The agreement describes the terms, conditions and purposes of the commercial support grant and must be signed by the commercial supporter, joint provider and ACCME accredited provider (UHMS.

Undersea and Hyperbaric Medical Society is committed to presenting CME activities that promote improvements or quality in healthcare and are independent of the control of commercial interests. As part of this commitment, Undersea and Hyperbaric Medical Society has outlined in this written agreement the terms, conditions, and purposes of commercial support for its CME activities. Commercial Support is defined as financial, or in-kind, contributions given by a commercial interest, which is used to pay all or part of the costs of a CME activity.

The ACCME defines a Commercial Interest as any entity producing, marketing, re-selling, or distributing health care goods or services, consumed by, or used on, patients. The ACCME does not consider providers of clinical service directly to patients to be commercial interests. For more information, visit [www.accme.org](http://www.accme.org).

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|  **Joint Provider:** |  |
| **Mailing Address:** |  |
|  |
|  |
| **Activity Director:** |  |
| **Email:**  |  | Phone: |  |
| **Activity Title** |  |
| **Activity Date:**  |  |
| **Website for activity:** |  |

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| **Commercial Supporter Company/Name:** |  |
| **Mailing Address:** |  |
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|  |
| **Contact Name:** |  |
| **Email:**  |  | Phone: |  |

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| **Commercial Support Provided** |  | **Financial** |  | **In-Kind (books, venue space, satchels)** |
| **Financial Amount Provided:** |  |
| **Description of In Kind Support:** |  |

|  |
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| **Financial Commercial Support will be used for the following (list below):** |
| **Speaker Honoraria** | **Speaker Expenses (Itemize below)** | **Meeting Expenses(Itemize below)** | **Other (list below)** |
|  |  |  |  |

 **Terms, Conditions, and Purposes**

**Independence**

1. This activity is for scientific and educational purposes only and will not promote any specific proprietary business interest of the Commercial Interest.

2. The Accredited Provider is responsible for all decisions regarding the identification of educational needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content of the CME, selection of education methods, and the evaluation of the activity.

**Appropriate Use of Commercial Support**

3. The Accredited Provider will make all decisions regarding the disposition and disbursement of the funds from the Commercial Interest.

4. The Commercial Interest will not require the Accredited Provider to accept advice or services concerning teachers, authors, or participants or other education matters, including content, as conditions of receiving this grant.

5. All commercial support associated with this activity will be given with the full knowledge and approval of the Accredited Provider. No other payments shall be given to the director of the activity, planning committee members, teachers or authors, joint sponsor, or any others involved with the supported activity.

6. The Accredited Provider will upon request, furnish the Commercial Interest documentation detailing the receipt and expenditure of the commercial support.

**Commercial Promotion**

7. Product-promotion material or product-specific advertisement of any type is prohibited in or during the CME activity. The juxtaposition of editorial and advertising material on the same products or subjects is not allowed. Live or enduring promotional activities must be kept separate from the CME activity. Promotional materials cannot be displayed or distributed in the education space immediately before, during or after a CME activity. Commercial Interests may not engage in sales or promotional activities while in the space or place of the CME activity.

8. The Commercial Interest may not be the agent providing the CME activity to the learners.

**Disclosure**

9. The Accredited Provider will ensure that the source of support from the Commercial Interest, either direct or “in-kind,” is disclosed to the participants, in program brochures, syllabi, and other program materials, and at the time of the activity. This disclosure will not include the use of a trade name or a product-group message. The acknowledgment of commercial support may state the name, mission, and clinical involvement of the company or institution and may include corporate logos and slogans, if they are not product promotional in nature.

By signing below, the Commercial Supporter, Joint Provider and Undersea and Hyperbaric Medical Society agree to abide by all requirements of the ***ACCME Standards for Commercial SupportSM***

|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
| *Accredited Provider UHMS CME Coordinator*  |  | *Date* |  | *Program Director or Administrator**Joint Provider* |  | *Date* |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *Contact Person**Commercial Supporter* |  | *Date* |

ATTACHMENT 10: DETAILED HOUR-BY-HOUR SCHEDULE WITH FACULTY SAMPLE

Calculate CME hours for each day and total at the bottom to the nearest quarter hour
(e.g. .25, .50, .75, 1.00).

Note: Lunch and breaks are deleted from the CME hour count, but should be noted within the schedule so all time is accounted for. CME hours are only counted as faculty to attendee participation.

**Sample Academic Schedule**

|  |
| --- |
| **DAY 1 / Monday, January 5, 2014** |
| **Objective** | **Start Time** | **Stop Time** | **Lecture Title** | **Faculty** |
|  | 8:00am | 9:00am | Hyperbaric Medicine | John Smith, MD |
|  | 12:00pm | 12:30pm | Lunch (is not counted for CME) |  |
|  | 12:30pm | 1:00pm | Wound Care | Jane Smith, RN |
| **TOTAL CME HOURS DAY 1:**  |
| **DAY 2 / Tuesday, January 6, 2014** |
|  | 8:00am | 9:00am | Hyperbaric Medicine | John Smith, MD |
|  | 12:00pm | 12:30pm | Lunch (is not counted for CME) |  |
|  | 12:30pm | 1:00pm | Wound Care | Jane Smith, RN |
| **TOTAL CME HOURS DAY 2:** |

|  |  |
| --- | --- |
| **DATE:** | **# of CME hours** |
| Day 1 |  |
| Day 2 |  |
| Day 3 |  |
| Day 4 |  |
| Day 5 |  |
| **Total CME Hours:** |  |

**Please note:** **UHMS Approved Introductory Courses** must submit a detailed hour-by-hour objective form and CME Form 104. UHMS Approved Introductory Courses must be at least 40 hours of HBO2 specific topics, face-to-face instruction and include hands on training and evaluation at completion.

**Faculty Qualifications:** Clinical instructors must possess a DO, MD, PhD, or equivalent degree, as well as have the appropriate level of training and experience in the topic they present, except those hours directed to clinical nursing that must be taught by an appropriately qualified RN, LVN, or equivalent. Basic physiology and technical instructors must possess the appropriate level of training and experience in the topic they present. It is the responsibility of the Activity Director to ensure the quality and appropriateness of instructors.

|  |  |  |
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| UHMS Logo Black  | **Faculty & Planner Individual Disclosure** | **Form CME 110****Page 1 of 2** |

**Disclosure Policy:** As an accredited sponsor of CME, the UHMS must ensure balance, independence, objectivity, and scientific rigor in all its educational activities. The intent of financial disclosure is not to prevent a speaker from presenting, but rather to inform the UHMS and planners of any financial relationships so that conflicts can be resolved prior to the activity. All speakers and planners participating in CME activities must disclose in writing to the UHMS, and verbally to their audiences, any relevant financial relationships with commercial interests related to the content of their presentation.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Faculty Member |  | Planning Committee |

|  |  |
| --- | --- |
| Faculty/Planner Name: |  |
| Activity Name: |  |
| Activity Date: |  |
| Topic(s): |  |

**Definitions of Commercial Interest / Financial Relationships are at PAGE 2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes |  | No | Do you have any relevant financial relationships with proprietary entities producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients related to the content of this activity? The ACCME does not consider providers of clinical service directly to patients to be commercial interests. |
|  |  |
|  | Yes  |  | No | Have you and/or your spouse or partner had a relevant financial relationship in any amount, which occurred in the twelve-month period preceding the time you were asked to assume a role controlling content of the CME activity, and which relates to the content of the educational activity, causing a conflict of interest? |
|  |  |

**If you have answered yes to either of the questions above, please identify the company and the nature of the relationship below:**

|  |  |
| --- | --- |
|  | **Nature of Relationship** |
| **Commercial Interest (Manufacturer/Provider/Commercial Supporter)**- add more lines if necessary | Employment | Leadership | Research Funding | Consultant | Speaker Bureau | Stock or Investment | OtherComp |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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**Please read and initial the following guidelines to indicate your understanding and willingness to comply with each statement.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | I have disclosed all relevant financial relationships, and I will disclose this information to learners verbally (for live activities) and in print through a disclosure powerpoint slide immediately after my title slide and prior to my educational material.  |  |  | If I am providing recommendations involving clinical medicine, they will be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in patient care. All scientific research referred to, reported or used in CME in support of justification of a patient care recommendation will conform to the generally accepted standards of experimental design, data collection and analysis. |
|  | The content and/or presentation of the information with which I am involved will promote quality or improvements in healthcare and will not promote a specific proprietary business interest of a commercial interest. Content for this activity, including any presentation of therapeutic options, will be well-balanced, evidence-based and unbiased. |  |  | If I am discussing specific healthcare products or services, I will use generic names to the extent possible. If I need to use trade names, I will use trade names from several companies when available, and not just trade names from any single company.  |
|  | I have not and will not accept any honoraria, additional payments or reimbursements beyond that which has been agreed upon directly with the Activity Director. |  |  | If I am discussing any product use that is off label, I will disclose that the use or indication in question is not currently approved by the FDA for labeling or advertising. |
|  | I understand that the Activity Director may need to review my presentation and/or content prior to the activity, and I will provide educational content and resources in advance as requested. |  |  | If I have been trained or utilized by a commercial entity or its agent as a speaker (e.g., speaker’s bureau) for any commercial interest, the promotional aspects of that presentation will not be included in any way with this activity.  |
|  | I understand that my presentation must be educational, and not promotional, in nature. |  |  | If I am presenting research funded by a commercial company, the information presented will be based on generally accepted scientific principles/ methods, and will not promote the commercial interest of the funding company. |

**I have carefully read and considered each item in this form and have completed it to the best of my ability and understand my disclosure obligations as outlined above.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Signature of Faculty/Planner**  |  | **Date** |
| UHMS Logo Black  | **Faculty & Planner Individual Disclosure** | **Form CME 110****Page 1 of 2** |

|  |  |
| --- | --- |
| Faculty/Planner Name: |  |
| Activity Name: |  |
| Activity Date: |  |
| Topic(s): |  |

**DEFINITIONS:**

**Commercial Interest:** The ACCME defines a “commercial interest” as any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The ACCME does not consider providers of clinical service directly to patients to be commercial interests.

**Financial relationships:** Financial relationships are those relationships in which the individual benefits by receiving, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g., stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit. Financial benefits are usually associated with roles such as independent contractor (including contracted research), consulting, promotional speaking and teaching, membership on advisory committees or review panels, board membership, and other activities for which remuneration is received or expected. The ACCME considers relationships of the person involved in the CME activity to also include financial relationships of a spouse or partner.

**Relevant financial relationships:** Relevant financial relationships are financial relationships in any amount, which occurred in the twelve-month period preceding the time that the individual was asked to assume a role controlling content of the CME activity, and which relate to the content of the educational activity, causing a conflict of interest. The ACCME considers financial relationships to create conflicts of interest in CME when individuals have both a financial relationship with a commercial interest and the opportunity to affect the content of CME about the products or services of that commercial interest. The potential for maintaining or increasing the value of the financial relationship with the commercial interest creates an incentive to influence the content of the CME—an incentive to insert commercial bias. The ACCME has not set a minimum dollar amount for relationships to be considered relevant and does not use the term significant to describe financial relationships. Inherent in any amount is the incentive to maintain or increase the value of the relationship.

**Conflict of Interest:** Circumstances create a conflict of interest when an individual has an opportunity to affect CME content about products or services of a commercial interest with which he/she has a financial relationship.

**BELOW FOR ACTIVITY DIRECTOR/COORDINATOR ONLY**

**NOTE:** Disclosures can now be accepted through online collection as long as all of the data on this form is clearly explained and received from all faculty members and planners. The Course Director is responsible for reviewing all disclosure forms and attesting if there are any potential conflicts and specific details of how they were resolved. It is required to submit a spreadsheet with all of the faculty/planner disclosures that can be exported from an online collection and submitted with all of the information included. An attestation with electronic signature is acceptable for online collection. Online disclosure forms must be approved by UHMS prior to acceptance.

* The provider must be able to show that everyone who is in a position to control the content of an education activity has disclosed all relevant financial relationships with any commercial interest to the provider. The ACCME defines "'relevant' financial relationships” as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.
* An individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a teacher, or an author of CME, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the CME activity.
* The provider must have implemented a mechanism to identify and resolve all conflicts of interest prior to the education activity being delivered to learners. Please check the mechanism used below to resolve all conflicts prior to the activity.

**Comments -**Resolution of potential conflicts:

|  |  |  |  |
| --- | --- | --- | --- |
|  | No relevant relationship(s) to resolve |  | Provided talking points/outline |
|  | Restricted presentation to clinical data |  | Data, slides added or removed |
|  | Reassigned faculty’s lecture/topic |  | Reviewed content – free of commercial bias |
| Notes: |  |
|  |
| Signature of Activity Director/Coordinator |  | Date: |  |

UHMS APPROVED INTRODUCTORY TRAINING COURSES ONLY

The following section are requirements for UHMS approved Introductory Training Courses Only.

Introductory Training Courses must be at least 40 hours of HBO2 specific topics, live instruction, include hands on training with evaluation and examination at completion.

**Faculty Qualifications:** Clinical instructors must possess a DO, MD, PhD, or equivalent degree, as well as have the appropriate level of training and experience in the topic they present, except those hours directed to clinical nursing that must be taught by an appropriately qualified RN, LVN, or equivalent. Basic physiology and technical instructors must possess the appropriate level of training and experience in the topic they present. It is the responsibility of the Activity Director to ensure the quality and appropriateness of instructors.

|  |
| --- |
| **ADDITIONAL REQUIREMENTS FOR INTRODUCTORY TRAINING COURSE (live 40 Hour Course)** |
| Attachment 12 | **Brief CV/Resume** for each faculty member to ensure they are appropriately credentialed and trained to present their topic. |
| Attachment 13 | **UHMS Designated Introductory Training Course Schedule Checklist**: please list the page number each topic is found within the detailed hour-by-hour schedule with objectives listed under **Form CME 104 to correlate with ATTACHMENT 10: Detailed Scheduled with hour-by-hour objectives.** |
| Attachment 14 | **Certificate of Attendance:** Must not state any CME hour statements and include only the participant name, course title, course date, hours it was approved for but may not designate the participant earning any hours. A CME certificate will be sent to all MD’s/DO’s to designate how many hours earned.  |

|  |  |  |
| --- | --- | --- |
| UHMS Logo Black  | **UHMS Designated Introductory Course in Hyperbaric Medicine Application** | **Form CME 104** |
| **Activity Title:** |   | **Date Submitted:** |  |
| **Responsible Organization:** |  |
| **Director / Administrator:** |   |

A UHMS designated introductory course in hyperbaric medicine is expected to require a minimum of 40 hours of faculty to participant instruction, formal assessment upon completion, some element of practical chamber‑side instruction, and must be documented by a certificate of completion.

Below is a list of elements required in a UHMS Designated Introductory Course in Hyperbaric Medicine. Please attach:

a) Detailed hourly lesson objectives. Cross reference each lesson objective with the corresponding element #. Annotate on this checklist the page # at which each element can be found.

b) A copy of the course certificate of completion.

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| ELEMENT Page #

|  |  |  |
| --- | --- | --- |
|  | 1. Historical Considerations
 |  |
|  | * 1. Historical perspective of hyperbaric medicine
 |  |
|  | * 1. Evolution of UHMS guidelines for using HBO2
 |  |
|  | * 1. Other standards and guidelines
 |  |

|  |  |  |
| --- | --- | --- |
|  | 1. Physics of Hyperbaric Exposure
 |  |
|  | * 1. Physical laws applicable to barotrauma and hyperoxygenation
 |  |

|  |  |  |
| --- | --- | --- |
|  | 1. Mechanisms of Hyperbaric Oxygen
 |  |
|  | * 1. Oxygen physiology, pharmacology, & biochemistry
 |  |

|  |  |  |
| --- | --- | --- |
|  | 1. Air Decompression Procedures
 |  |
|  | * 1. Decompression theory
 |  |
|  | * 1. Air decompression tables
 |  |

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| --- | --- | --- |
|  | 1. UHMS Accepted Indications: Their Scientific Basis and Treatment Protocols
 |  |
|  | * 1. Decompression sickness
 |  |
|  | * 1. Air or gas embolism
 |  |
|  | * 1. Carbon monoxide poisoning & smoke inhalation
 |  |
|  | * 1. Gas gangrene (Clostridial myonecrosis)
 |  |
|  | * 1. Crush injury, compartment syndrome, & other acute traumatic ischemias
 |  |
|  | * 1. Arterial Insufficiencies Central retinal artery occlusion, Enhancement of healing in selected problem wounds
 |  |
|  | * 1. Exceptional blood loss (anemia)
 |  |
|  | * 1. Necrotizing soft tissue infections
 |  |
|  | * 1. Osteomyelitis, refractory
 |  |
|  | * 1. Radiation tissue damage
 |  |
|  | * 1. Skin grafts and flaps (compromised)
 |  |
|  | * 1. Thermal burns
 |  |
|  | * 1. Intra cranial abscess
 |  |
|  | * 1. Other uses of HBO2
 |  |

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| --- | --- | --- |
|  | 1. Patient Assessment and Management
 |  |
|  | * 1. Tissue oxygen assessment
 |  |
|  | * 1. Patient evaluation and selection for HBO2 treatment
 |  |
|  | * 1. Plan of treatment (assessment of treatment, endpoints)
 |  |
|  | * 1. Wound care
 |  |
|  | * 1. Care of diabetics during HBO2
 |  |
|  | * 1. Management of the critical care patient during HBO2
 |  |
|  | * 1. Infection control
 |  |
|  | * 1. Documentation (e.g., record keeping, medical photography)
 |  |
|  | * 1. Quality assurance
 |  |

 | ELEMENT Page #

|  |  |  |
| --- | --- | --- |
|  | 1. Side Effects and Contraindications
 |  |
|  | * 1. Oxygen toxicity
 |  |
|  | * 1. Other risk factors
 |  |
|  | * 1. Contraindications
 |  |
|  | * 1. Management of complications
 |  |

|  |  |  |
| --- | --- | --- |
|  | 1. Hyperbaric Chamber Systems
 |  |
|  | * 1. Operating procedures
 |  |
|  | * 1. Breathing gas systems
 |  |
|  | * 1. Ancillary support equipment
 |  |
|  | * 1. Environmental systems and their operations
 |  |

|  |  |  |
| --- | --- | --- |
|  | 1. Hyperbaric Safety and Emergency Procedures
 |  |
|  | * 1. Safety codes and standards
 |  |
|  | * 1. Operational, electrical, and fire safety
 |  |
|  | * 1. Emergency procedures
 |  |

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| --- | --- | --- |
|  | 1. Administrative/ Management Issues
 |  |
|  | * 1. Reimbursement information
 |  |
|  | * 1. Management responsibilities
 |  |
|  | * 1. Professional societies and resources
 |  |

|  |  |  |
| --- | --- | --- |
|  | 1. Clinical and Technical Practicum

 Practical experience and observations in: |  |
|  | * 1. Patient assessment and management
 |  |
|  | * 1. Hyperbaric chamber operations
 |  |
|  | * 1. Ancillary hyperbaric equipment
 |  |

|  |  |  |
| --- | --- | --- |
|  | 1. Evaluation
 |  |
|  | * 1. Final written examination
 |  |
|  | * 1. Course critique
 |  |

***Those applying for a UHMS Designated Introductory Course in Hyperbaric Medicine must submit this checklist with attachments as part of the UHMS CME Activity Application (Form CME 102)***UHMS USE ONLY

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Instructors possess the appropriate level of training and experience in the topic they present. |  |  |
| Course is at least 40 hours duration |  |  |
| Certificate of completion is enclosed |  |  |

|  |  |
| --- | --- |
|  | Approved as a UHMS Designated Introductory Course in Hyperbaric Medicine |
|  | Not Approved (Comments Attached) |

|  |  |
| --- | --- |
| ***Approval Date*** | ***Expiration Date*** |
|  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*UHMS Education Committee Chairperson* |

ATTACHMENT 14: CERTIFICATE OF COMPLETION FOR INTRODUCTORY COURSE SAMPLE

[LOGO/NAME OF RESPONSIBLE ORGANIZATION]

**This certificate attests that**

[Name of Participant]

**Has successfully completed the live educational activity**

**[Name of Activity]**

**Conducted at**

**[Location]**

**[Date]**

The Undersea and Hyperbaric Medical Society has reviewed and approved this activity as a UHMS Designated Introductory Course in Hyperbaric Medicine. This activity meets the UHMS minimum requirements including 40 hours of face-to-face instruction.



|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Activity Director/Coordinator |  | Date: |  |

UHMS REQUIRED CLOSING DOCUMENTS AFTER COMPLETION OF COURSE

|  |
| --- |
| **UPON COMPLETION OF ACTIVITY THE FOLLOWING ATTACHMENTS MUST BE SUBMITTED** |
| Attachment 4 | The **disclosure information** **as provided to learners** about relevant financial relationships (or absence of relevant financial relationships) that each individual in a position to control the content of CME disclosed to provider. |
| Attachment 5 | **Evaluation Summary:** The data or information generated form this activity about changes achieved in learners competence or performance or patient outcomes. Please submit a summary of participant evaluations reflecting what changes were achieved in relation to the identified practice gap(s).  |
| Attachment 6 | The ACCME accreditation statement for this activity, **as provided to learners (from program book, powerpoint slide, etc)** |
| Participant List | **Participant List** of all attendees, including full name, credentials, address, email. A CME certificate will be emailed to all MD/DO’s. A letter of attendance can be sent to any non-physician at your request. The fee is $25 per certificate for all attendees.  |
| Change in CME Form 106 | **Change in CME Form 106** to be submitted in advance noting changes to faculty, schedule, CME hours, location, date, Course Director, etc. This is to be submitted to the Education Committee Chair to approve prior to the course taking place. |
| PAYMENT FORM | Check or credit card payment at $25/CME Certificate processed. CME Certificates are sent to MD’s/DO’s. Letters of attendance to non-physicians may also be requested at $25/Certificate. All payments should be sent to: UHMS, 631 US Highway 1, Suite 307, North Palm Beach, Florida, USA. Closing documents should be submitted electronically to stacy@uhms.org |

|  |  |  |
| --- | --- | --- |
|  | CME Activity Closing Report | **Form CME 105** |

**Activity Information**

|  |  |
| --- | --- |
| **Activity Title:** |  |
| **Activity Location:** |  |
| **Activity Date:** |  |
| **Number of CME hours:** |  |
| **Responsible Organization:** |  |
| **Activity Director/Administrator:** |  | **Email:**  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Participants** | **Number of Participants** | **Number Requiring****CME Certificate/****Letter of Attendance**  | **Capitation fee at****$25 per certificate** |
| **Physicians (MDs & DOs)** |  |  | $ |
| **All Other Attendees** |  |  | $ |
| **TOTAL** |  |  | $ |

|  |
| --- |
| **If Commercial Support Received, complete the below** |
| Total # of Commercial Supporters |  |
| Total monetary amount received |  |
| In-Kind support received (please list) |  |

**I certify that verbal and/or written disclosure of faculty/planner relevant financial relationships and commercial support was given to participants prior to the CME activity.**

|  |
| --- |
|  |

***Signature of Activity Director or Administrator***

**Credit Card Information** (American Express, MasterCard, Visa, Diners)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Card Number | Expiration Date |
|  |
| Card Holder Printed Name |
|  |
| Signature |
| **PLEASE ATTACH THE FOLLOWING ITEMS TO THIS REPORT****[ ]  Credit Card** or **Check** based on the capitation fee made payable to the UHMS CME Program.**[ ]  List of participants** All participants included with full name, credentials, address, email, CME hours earned in an excel spreadsheet (see sample participant list on website)**[ ]** The activity **final printed announcement or brochure** that contains the accreditation, designation, disclosure and disclaimer policy statements, and expected results.**[ ]** The **CME Activity Evaluation Summary** Evaluation summary to reflect the activity increased knowledge, competence and/or performance upon completion and how it is measured. (do not send critique sheets)**[ ]** Submit **Faculty and Planner** **Disclosure to Participant (Form CME 115)** as it was given to the learners. The disclosure page should be signed by the Activity Director or Administrator.**[ ]** Final **Expense Report** (only is commercial support was provided) reflecting total amount of commercial support, advertising/exhibit income, total income and total expense for this specific activity only.**[ ]** Indicate any **changes** made in the CME activity since original approval by the UHMS (If changes were made, submit a Change in CME Activity form, Form CME 106) |
|
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Please submit this report electronically to stacy@uhms.org. Payments should be sent to UHMS Executive Office, 631 U.S. Highway 1, Suite 307, North Palm Beach, FL 33408. Ph: 919-490-5140 X 101, Fax: 919-490-5149.

ATTACHMENT 4: DISCLOSURE INFORMATION AS PROVIDED TO LEARNERS AT ACTIVITY

Samples below:

1.Powerpoint slide with disclosure information noting disclosure being made prior to start of activity, all commercial supporters with the type of support noted (financial amount or in-kind).

****

2. You may also copy and scan Attachment 2-3 “INDIVIDUALS IN CONTROL OF CONTENT DISCLOSURE TO PARTICIPANTS” noted previously in this application exactly as it was in the program book or presented prior to the activity.

ATTACHMENT 5: SUMMARIZED DATA OR INFORMATION GENERATED FORM THIS ACTIVITY ABOUT CHANGES ACHIEVED IN LEARNERS COMPETENCE OR PERFORMANCE OR PATIENT OUTCOMES.

1. **Please indicate:** O MD/DO O DPM O RN O CHT O CHRN O RRT O Student O Other
2. **This session has increased, improved, or positively impacted my: (select all that apply)**

 O Knowledge O Competence O Performance O Patient Outcomes O No Change

1. **This activity is free of commercial bias\* or influence?**

 O Yes O No, please explain:

*\*Commercial bias is defined as a personal judgment in favor of a specific product or service of a commercial interest.*

1. **The overall objective was met** O Yes O No
2. **This activity met my educational needs** O Yes O No
3. **The references were appropriate** O Yes O No
4. **The educational format(s) is appropriate for the setting, objective, and desired result** O Yes O No
5. **The content matches my current or potential scope of professional activities** O Yes O No
6. **This activity has addressed competencies that are applicable with the following: (select all that apply):**

 O Patient care or patient-centered care

 O Interpersonal and communication skills

 O Practice-based learning & improvement

 O Professionalism

 O System-based practice

 O Interdisciplinary teams

 O Quality improvement

 O Utilize informatics

O Medical knowledge

O Employ evidence-based practice

O None of the above

1. **How will you change your practice as a result of attending this session (select all that apply)?**

O Create/revise protocols, policies, and/or procedures – please explain:

 O Change the management and/or treatment of my patients – please explain:

 O This activity validated my current practice

 O I will not make any changes to my practice because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 O Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please indicate any barriers you perceive for implementing these changes.**

 O Cost O Lack of time to assess/counsel patients

 O Lack of experience O Reimbursement/insurance issues

 O Lack of opportunity (patients) O Patient compliance issues

 O Lack of resources (equipment) O Lack of consensus or professional guidelines

 O Lack of administrative support O Other, please specify:

 O No barriers

1. **How will you address these barriers to implement changes in knowledge and/or behavior?**
2. **What changes might be made in the overall format of this CME activity in order to be the most appropriate for the content presented (select all that apply)?**

O Format is appropriate; no changes needed O Add a hands-on instructional component

O Include more case-based presentations O Schedule more time for Q and A

 O Increase interactivity with attendees O Other, please describe:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 14**. Speaker(s) (Overall)** | **Excellent** | **Above Average** | **Average** | **Below Average** | **Poor** |
| Overall Presentation | O | O | O | O | O |
| Organized Presentation: clearly presented and explained concepts | O | O | O | O | O |
| Useful, relevant & practical information | O | O | O | O | O |

 **Comments:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Thank you for providing valuable feedback to help us evaluate changes in competence, performance and/or patient outcomes to assist with planning and implementing future educational activities.**

ATTACHMENT 6: THE ACCME ACCREDITATION STATEMENT FOR THIS ACTIVITY, AS PROVIDED TO LEARNERS (FROM PROGRAM BOOK, POWERPOINT SLIDE, ETC)

Samples below:

1.Powerpoint slide with disclosure information noting disclosure being made prior to start of activity, all commercial supporters with the type of support noted (financial amount or in-kind).

****

2. You may also copy and scan a page from your program book reflecting the accreditation statement as it was provided to the participants prior to the start of the educational activity.

|  |  |  |
| --- | --- | --- |
| UHMS Logo Black  | Change in CME Activity | **Form CME 106** |

|  |  |
| --- | --- |
| Date Submitted: |  |

**Activity Information for Previous Approved Activity**

|  |  |
| --- | --- |
| **Activity Title:** |  |
| **Activity Location:** |  |
| **Activity Date:** |  |
| **Number of CME hours approved:** |  |
| **Responsible Organization:** |  |
| **Activity Director/Administrator:** |  | **Ph:**  |  | **Email:** |  |
| **Original Approval Date:** |  | **Exp. Date:** |  |

**Proposed Changes**

|  |  |  |
| --- | --- | --- |
|  | **New Activity Title** |  |
|  | **New Activity Location** |  |
|  | **New Activity Dates** |  |
|  | **Activity Changed from One-Time to Ongoing** |  |
|  | **New Activity Director** | **Name:** |  |
|  | **Title:** |  |
|  | **Address:** |  |
|  | **City/State/Zip:** |  |
|  | **Phone/Fax:** |  |
|  | **Email:** |  |
|  | **New Activity Administrator** | **Name:** |  |
|  | **Title:** |  |
|  | **Address:** |  |
|  | **City/State/Zip:** |  |
|  | **Phone/Fax:** |  |
|  | **Email:** |  |
|  | **Change *AMA PRA Category 1 credit hours TM*:** | **from:** | **to:** |
|  | **New Faculty**  | **Submit Faculty List, CVs (2 page max for each), and Disclosures** |
|  | **Change in Academic Schedule**  | **Submit new schedule** |
|  | **Remove from Administrative Hold**  | **Submit letter of explanation** |

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature of Activity Director or Administrator Date***

|  |  |
| --- | --- |
| **Please Return This Report and Attachments To:Heather Murphy-Lavoie , MD**UHMS Education Committee Chair419 Cherokee StNew Orleans, LA 70118[hmurph@cox.net](file:///C%3A%5CUsers%5Cstacyrupert%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CCME%20FORMS%5C2010%20New%20Forms%5Chmurph%40cox.net) (preferred)Phone/Fax: (504) 866-4289 | **UHMS USE ONLY** Change Approved\_\_\_\_\_\_\_\_\_\_ hours *AMA PRA Category 1 Credit(s) TM* Change Not Approved ***(See attached comments)***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***UHMS Education Committee Chair Date*** |