

For office use only:  
 Direct Sponsorship  
 Joint Providership  
 For office use only: Direct Sponsorship Joint Providership

# CME Application and Planning Worksheet

## General Information

The CME planning process is based on criteria of the Accreditation Council for Continuing Medical Education (ACCME) and sound adult learning principles. The MORE Foundation CE Committee has the responsibility for assuring that CME activities meet these requirements. This application is an essential step that will guide you through the planning process. Each section references a letter/number (e.g., C5) which refers to the relevant ACCME Criterion. For more information on the ACCME criteria, refer to the [ACCME Essential Areas and their Elements](#).

Except where noted, all sections must be completed. Email the completed document and attachments to: [CME@more-foundation.org](mailto:CME@more-foundation.org)

<b>Activity Information</b>		
Date Submitted:	Activity Contact (name, email and phone):	
Proposed Activity Title:		
Department/Organization:		<b>Anticipated Number of Attendees:</b>
Speaker (s):		Honoraria <input type="checkbox"/> No <input type="checkbox"/> Yes Amount
Proposed Activity Date(s):	Time (if live event):	Location (if live event):
<b>Proposed Activity Type</b> (Select all that apply by placing an X in the appropriate box)		<b>C5</b>
<input type="checkbox"/>	<b>Live Activity</b> (Course, Symposium, Workshop, Conference, Live Webcast, Livestream)	
<input type="checkbox"/>	<b>Regularly Scheduled Series (RSS)</b> (Grand Rounds, Tumor Board, Case Conference, Journal Club, M&M, etc.) Frequency: <input type="checkbox"/> 1/Week <input type="checkbox"/> 2/Week <input type="checkbox"/> 2/Month <input type="checkbox"/> Quarterly <input type="checkbox"/> Other:	
<input type="checkbox"/>	<b>Enduring Material (Provide a copy or link of the enduring material as part of the CME/CE Review)</b> <input type="checkbox"/> CD-ROM <input type="checkbox"/> Internet Archive / On Demand <input type="checkbox"/> Monograph <input type="checkbox"/> Newsletter <input type="checkbox"/> Other: How long are you seeking CME approval for this enduring material? (up to 3 years)	
<input type="checkbox"/>	<b>Performance Improvement CME</b>	
<input type="checkbox"/>	<b>Other</b>	
<b>Credit Type: How many credit hours are requested?</b>		
<input type="checkbox"/> <a href="#">American Medical Association</a> AMA PRA Category 1 Credits™		
<input type="checkbox"/> Other (e.g. PT, nursing, AT)		
<b>Are you seeking Maintenance of Certification (MOC)/Continuing Certification (CC)?</b>		<input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, check specialty(s) below
<input type="checkbox"/> Anesthesiology (ABA) <input type="checkbox"/> Internal Medicine (ABIM) <input type="checkbox"/> Ophthalmology (ABO)		
<input type="checkbox"/> Otolaryngology, Head, & Neck (ABOHNS) <input type="checkbox"/> Pathology (ABPath) <input type="checkbox"/> Pediatrics (ABP)		

## Leadership and Administrative Staff Support

<b>Activity Medical Director/Moderator</b> The physician or basic scientist who has overall responsibility for planning, developing, implementing, and evaluating the content and logistics of a certified activity.				
Name			Degree(s)	
Title	Affiliation		Department	
Address		City	State	ZIP
Phone	Fax		Email	

DISCLOSURE Statement for this activity submitted

<b>Activity Co-Director (optional)</b> The individual who shares responsibility for planning the certified activity. Designating an Activity Co-Director is optional, but strongly encouraged, for a jointly sponsored or co-sponsored activity.				
Name			Degree(s)	
Title	Affiliation		Department	
Address		City	State	ZIP
Phone	Fax		Email	

DISCLOSURE Statement for this activity submitted

<b>Administrative Coordinator/CME Associate</b> The individual responsible for the operational and administrative support of the certified activity; this is usually an administrative or staff assistant.				
Name			Degree(s)	
Title	Affiliation		Department	
Address		City	State	ZIP
Phone	Fax		Email	

DISCLOSURE Statement for this activity submitted

<b>Planning Committee</b> <i><b><u>In addition to the activity medical director, co-director, and/or CME Associate, list the names, degrees, titles, affiliations and emails of persons chiefly responsible for the design and implementation of this activity. Use additional sheets if necessary. Note, all individuals listed will be required to complete a CME disclosure.</u></b></i>				
Name	Marc Jacofsky		Degree(s)	PhD
Title	Executive Director	Affiliation	MORE Foundation	Email
				marc.jacofsky@more-foundation.org
Name	Victoria Icenogle		Degree(s)	
Title	Business Manager	Affiliation	MORE Foundation	Email
				victoria.icenogle@more-foundation.org
Name			Degree(s)	
Title		Affiliation		Email
Name			Degree(s)	

Title		Affiliation		Email	
Name				Degree(s)	
Title		Affiliation		Email	
Name				Degree(s)	
Title		Affiliation		Email	

DISCLOSURE Statements for this activity submitted

## Planning Process

The CME planning process is based on a foundation of needs assessment which serves to identify professional practice gaps of the intended audience, articulate the needs, and outline the objectives and expectations necessary to design learning activities that will change competence, performance, and/or patient outcomes.

<b>Identify Practice Gaps</b> <i>The practice gap is the difference between what actually occurs and what ideal or evidence-based practice should be. Define what the problem or needs might be based on what actually occurs versus what the ideal practice should be. Explain WHY this education is needed. (approximately &lt; 100 words)</i>	<b>C2, C3, C5</b>

<b>Needs Assessment Data and Source</b> <i>What sources did you use to identify the professional gaps? (Select all that apply) Provide data source and accompanying explanation as evidence for how professional practice gap exists or could exist if providers are not knowledgeable or skilled in the content that will be presented. Provide attached documentation, if needed, and/or narrative summary for each source chosen.</i>	<b>C2</b>
<input type="checkbox"/> New methods of diagnosis or treatment (knowledge) <input type="checkbox"/> Availability of new medication(s) or indications(s) (knowledge) <input type="checkbox"/> Development of new technology (knowledge) <input type="checkbox"/> Input from experts regarding advances in medical knowledge (knowledge) <input type="checkbox"/> Literature review (knowledge) <input type="checkbox"/> Data from outside sources, e.g., public health statistics (knowledge) <input type="checkbox"/> Survey of target audience (knowledge) <input type="checkbox"/> Quality assurance/audit data (Competence & Performance) <input type="checkbox"/> Professional society requirements (Competence & Performance)	<input type="checkbox"/> External requirements such as: National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare (JCAHO) or Health Plan Employer Data and Information Set (HEDIS). (Competence and Performance) <input type="checkbox"/> Continuing review of changes in quality of care as revealed by Quality Department, medical audit or other patient care reviews (Competence and Performance) <input type="checkbox"/> Referral patterns (Competence and Performance) <input type="checkbox"/> Legislative, regulatory or organizational changes effecting patient care (Knowledge, Competence and Performance) <input type="checkbox"/> Joint Commission Patient Safety Goal/Competency: _____ <input type="checkbox"/> Other: _____

<b>Identify Evidence Based Support</b> <i>Provide 1-3 references from the professional literature that provide evidence-based support for the education that will be presented.</i>	<b>C2</b>

<b>Identify Educational Needs</b> <i>State the educational need(s) that were determined to be the cause of the professional practice gap(s). Select <b>only</b> the type of need(s) that apply to this learning activity. Teaching and evaluation methods should correspond to the educational need. (approximately &lt; 50 words each)</i>		<b>C2, C3, C5</b>
<b>Type of Need</b>	<b>Educational Need</b>	
<input type="checkbox"/> Knowledge need(s)		
<input type="checkbox"/> Competence need(s)		
<input type="checkbox"/> Performance need(s)		

<b>Objectives and Expected Results</b> <i>Select the key identified educational needs listed above that you wish to address with this activity and list specific, measurable learning objective(s), the change type, and what is designed to change. (You may combine needs if appropriate or add rows as needed.)</i>		<b>C2, C3, C4, C5, C6, C10, C11</b>
<b>Learning Objective</b>	<b>Change Type</b>	<b>Designed to Change</b>
	<input type="checkbox"/> Competence <input type="checkbox"/> Performance <input type="checkbox"/> Patient Outcomes	
	<input type="checkbox"/> Competence <input type="checkbox"/> Performance <input type="checkbox"/> Patient Outcomes	
	<input type="checkbox"/> Competence <input type="checkbox"/> Performance <input type="checkbox"/> Patient Outcomes	

<b>How does this activity align with the mission of CME?</b> <i>Select all that apply by placing an X in the appropriate box. (It may be best to complete this after you have completed the planning process. Evaluation methods should correspond to activity intent.)</i>		<b>C1, C3</b>
<input type="checkbox"/>	Designed to produce changes in physicians resulting in improved knowledge and competence	
<input type="checkbox"/>	Designed to produce changes in physicians resulting in improved performance	
<input type="checkbox"/>	Designed to produce changes in physician practice resulting in improved patient outcomes	

<b>Target Audience</b> <i>Based on the above gap analyses and needs assessment, please select all that apply – at least one from each category. Make sure that the activity you have in mind is related to what learners actually do in their practice.</i>	<b>C4</b>
--	-----------

<b>Audience:</b>	<b>Geographic Locations:</b>	<b>Specialty:</b>	
<input type="checkbox"/> Primary Care Physicians <input type="checkbox"/> Specialty Physicians <input type="checkbox"/> Pharmacists <input type="checkbox"/> Physician Assistants <input type="checkbox"/> Nurse Practitioners <input type="checkbox"/> Physical/Occupational Therapists <input type="checkbox"/> Social Worker <input type="checkbox"/> Residents and Fellows <input type="checkbox"/> Registered Nurses <input type="checkbox"/> Respiratory Therapists <input type="checkbox"/> Students <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Local/Regional <input type="checkbox"/> National <input type="checkbox"/> International	<input type="checkbox"/> Anesthesiology <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Neurology <input type="checkbox"/> Oncology <input type="checkbox"/> Orthopedics <input type="checkbox"/> Pain Specialty	<input type="checkbox"/> Pediatrics <input type="checkbox"/> Psychiatry <input type="checkbox"/> Radiology <input type="checkbox"/> Rheumatology <input type="checkbox"/> Surgical Specialties: (specify) <input type="checkbox"/> Other: (specify)

<b>How will the content of the activity be made relevant to the learners' current and potential scope of practice?</b>
--

<b>Design Format</b> <i>The format for the activity should be based on adult learning principles. (Select all that apply by placing an X in the appropriate box)</i>	<b>C5</b>
---	-----------

<b>Format</b>	
<input type="checkbox"/> Lecture – interactive with Q&A <input type="checkbox"/> Panel Discussion <input type="checkbox"/> Case Presentation <input type="checkbox"/> Case discussion with Audience Interaction <input type="checkbox"/> Small Group Discussion <input type="checkbox"/> Problem-Solving <input type="checkbox"/> Laboratory Activity <input type="checkbox"/> Simulation <input type="checkbox"/> Demonstration <input type="checkbox"/> Brainstorming <input type="checkbox"/> Other (Describe):	Explain why this educational format is appropriate for this activity.

<b>Desirable Physician Attributes/Core Competencies</b> (select all that apply, at least 1) <i>CME activities should be developed in the context of desirable physician attributes. Place an X next to all American Board of Medical Specialties (ABMS)/Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC) or Interprofessional Education Collaborative competencies that will be addressed in this activity.</i>	<b>C6</b>
---	-----------

<input type="checkbox"/> Patient care/patient-centered care and procedural skills <input type="checkbox"/> Medical knowledge <input type="checkbox"/> Practice-based learning and improvement <input type="checkbox"/> Interpersonal and communication skills	<input type="checkbox"/> Apply quality improvement <input type="checkbox"/> Utilize informatics <input type="checkbox"/> Employ evidence-based practice <input type="checkbox"/> Values/Ethics for interprofessional practice <input type="checkbox"/> Roles/responsibilities
--	---

<input type="checkbox"/> Professionalism <input type="checkbox"/> System-based practice <input type="checkbox"/> Work in interdisciplinary teams	<input type="checkbox"/> Teams and teamwork <input type="checkbox"/> Interprofessional communication <input type="checkbox"/> Other (Describe):
--	---

<b>Faculty Selection</b> <i>(Select all that apply by placing an X in the appropriate box)</i>	<b>C7</b>
<b>Who will identify the presenter(s) and topic?</b>	
<input type="checkbox"/> Activity Chair/Moderator <input type="checkbox"/> CME/CE Committee <input type="checkbox"/> Other:	
<b>What criteria will be used in the selection of the presenters?</b>	
<input type="checkbox"/> Subject matter expertise <input type="checkbox"/> Excellence in teaching skills <input type="checkbox"/> Effective communication skills <input type="checkbox"/> Previous experience as a CME presenter <input type="checkbox"/> Other:	

<b>Faculty Disclosure</b> <i>Each faculty must complete a faculty disclosure form as part of the CME planning and approval process.</i>	<b>C7</b>
<i>What methods(s) of faculty disclosure to activity attendees will be used? Select all that apply by placing an X in the appropriate box. All selected methods must be demonstrated on activity materials.</i>	
<input type="checkbox"/> will include on presentation <input type="checkbox"/> will put on printed materials <input type="checkbox"/> will announce at start of activity <input type="checkbox"/> Other: (specify)	

<b>Evaluation and Outcomes</b>	<b>C3, C11</b>
<i>How will this activity be evaluated for its effectiveness? Based on the objectives and desired outcomes listed previously (i.e., changes in competence, performance, or patient health outcomes) which methods will be used? Select all appropriate methods of evaluation and other post-course evaluating mechanisms.</i>	
<b>Note:</b> MORE Foundation's policy is that a course evaluation must be completed to receive a CME/CE certificate. Summary data will be requested for the evaluation method(s) selected if obtained by joint partner.	
<b>KNOWLEDGE AND COMPETENCE</b>	
<i>Can learners apply what was learned?</i>	
<input type="checkbox"/> Post activity questionnaire <b>(minimum required)</b>	<input type="checkbox"/> Physician and/or patient surveys
<input type="checkbox"/> Audience response system (ARS)	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Customized pre and post-test	
<b>PERFORMANCE</b>	
<i>Have learners implemented what was learned?</i>	
<i>This may be obtained from actual data or from post activity self-assessment by the attendees.</i>	
<input type="checkbox"/> Adherence to guidelines (as determined by a survey)	<input type="checkbox"/> Chart audits for physician behavioral change
<input type="checkbox"/> Case-based studies	<input type="checkbox"/> Direct observations
<input type="checkbox"/> Customized follow-up survey/interview/focus group about actual change in practice at specified intervals	<input type="checkbox"/> Other, specify:
<b>PATIENT and/or POPULATION OUTCOMES</b>	
<i>Have learners implemented what they learned in a way that improves outcomes?</i>	
<i>This may be obtained from actual data or from post activity self-assessment by the attendees.</i>	
<input type="checkbox"/> Observe changes in health status measure	<input type="checkbox"/> Obtain patient feedback and surveys
<input type="checkbox"/> Observe changes in quality/cost of care	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Measure mortality and morbidity rates	
<b>Will MORE Foundation provide a web-based evaluation and certificates to the participant?</b>	
<input type="checkbox"/> Yes (The final evaluation tool must be received at least 3 weeks prior to the activity.)	
<input type="checkbox"/> No (The evaluation and draft certificate must be provided for approval.)	

**Commercial Support**

Commercial Support is allowed for CME activities; however, activities must be developed without the influence or support of any commercial entity. MORE Foundation must be aware of all financial support..

**C7, C8,  
C9, C10**

**Commercial Support and Exhibits**

- 1. Will this activity receive commercial support (financial or in-kind grants or donations) Note: exhibit fees are not considered commercial support.
  - No
  - Yes – Request Commercial Support Agreements from MORE Foundation that will be executed prior to the event.

**Please list your potential funding sources (if applicable):**

I have read and will abide by the [ACCME Standards for Integrity and Independence in Accredited Continuing Education](#)

2. Will this activity receive commercial support that is regarded promotional?  No  Yes

3. Will vendor/exhibit tables/booths be allowed at this activity?  No  Yes

If yes, attach a map of area for exhibitors in relation to the education. Or Describe location of exhibitors:

**Online Advertisement**

4. Would you like this event posted on MORE Foundation’s website?  No  Yes

5. Would you like this event posted on the ArMA calendar?  No  Yes

**I acknowledge that submission of this application does not constitute approval of CMEs, CNEs, or CEs. There is an application fee, which is not refunded after the CE Committee has reviewed the CME Planning and Application Worksheet.**

Applicant/Course Coordinator/Moderator Signature \_\_\_\_\_ Date \_\_\_\_\_

**Invoices shall be sent to:**

Name/Organization \_\_\_\_\_ ATTN: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Each CME/CE activity application is eligible for review upon presentation to the CE Committee and should include the following:

1. All information obtained on application form completed.
2. Program agenda (preliminary draft is acceptable)
3. Faculty qualification (CV or resume)
4. Faculty and planning committee disclosure forms
5. Promotional material (draft is acceptable)
6. Projected budget, if commercial support or exhibitor fees are planned
7. Proposed evaluation form
8. Proposed sign-in method
9. For enduring materials, provide
  - a. material or link
  - b. permission of presenter(s)

At least 3 weeks prior to the event:

1. Powerpoint presentation(s) if peer review is requested in letter of agreement
2. Final evaluation form
3. Certificate if not provided by MORE Foundation
4. Final program agenda, brochures, handouts, etc.
5. All promotional/marketing material
6. Executed commercial support agreements

Within 60 days of the completion of the CME activity, send the following via e-mail or to:

MORE Foundation  
PO Box 87535  
Phoenix, AZ 85080

1. Sign-in sheets or other record of those attending
2. Powerpoint presentation(s) or other documentation as pertinent for other methods of instruction (e.g. discussion questions for panel discussion)
3. Summary of completed evaluations if web-based evaluation is not done by MORE Foundation
4. Final budget

Questions can be addressed to: Marc Jacofsky, PhD at [CME@more-foundation.org](mailto:CME@more-foundation.org) or 623.537.5642

----- THIS SECTION FOR OFFICIAL USE BY MORE FOUNDATION CME COMMITTEE -----

**APPROVAL ACTION**

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

Approved for \_\_\_\_\_ *AMA PRA Category 1 Credits™*

Approved for \_\_\_\_\_ Other \_\_\_\_\_ CE Hours

Not approved \_\_\_\_\_

CE Committee Chair Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant notified: Date \_\_\_\_\_



MORE Foundation ensures balance, independence, objectivity, and scientific rigor in all its directly or jointly provided continuing education (CE). **All those with a role in a CE activity must disclose ALL financial relationships in any amount that has occurred in the past 24 months with ineligible companies. An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.** It is the responsibility of MORE Foundation to identify and manage relevant financial relationships prior to the activity. The presence of a financial relationship does not necessarily disqualify participation, but the financial relationship(s) must be disclosed to the CE Committee and the activity's participants. The management resolution provided by the CE Committee must be followed by the person with the relevant financial relationship(s).

<b>General Information and Role(s) in Continuing Education</b>	
<b>Event Title:</b>	<b>Date of Event:</b>
<b>Name (print)</b>	<b>e-mail:</b>
<b>Identify the prospective role(s) that this person may have in the planning and delivery of education. (select all that apply)</b>	
<input type="checkbox"/> Planner <input type="checkbox"/> Activity Director/Chair <input type="checkbox"/> Faculty/Presenter/Instructor/Teacher <input type="checkbox"/> Moderator  <input type="checkbox"/> Author/Writer <input type="checkbox"/> Reviewer <input type="checkbox"/> Other _____	

**Disclose ALL Financial Relationships that you have had in the past 24 months with ineligible companies** (see definition above). For each financial relationship, enter the name of the ineligible company and the nature of the financial relationship(s). There is no minimum financial threshold; we ask that you disclose ALL financial relationships, regardless of the amount, with ineligible companies. You should disclose all financial relationships regardless of the potential relevance of each relationship.

<b>Enter the Name of Ineligible Company</b>	<b>Enter the Nature of Financial Relationship(s)</b> <small>Examples include: employee, board member, founding/principal member, researcher (grant/research support), consultant, advisor, speaker, independent contractor (including contracted research), royalties, patent beneficiary, executive role, ownership interest, individual stocks and stock options.(Diversified mutual funds do not need to be disclosed. Research funding from ineligible companies should be disclosed by the principal or named investigator even if that individual's institution receives the research grant and manages the funds.)</small>	<b>Has the Relationship Ended?</b>  <small>Check this box if the financial relationship existed during the last 24 months but does not currently exist.</small>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

In the past 24 months, I have not had **any** financial relationships with any ineligible companies.

**I attest that the above information is correct as of this date of submission.**

<b>Signature:</b> <small>(digitally stamped or wet ink signature)</small>	<b>Date:</b>
--	--------------