



# Continuing Medical Education

Humboldt-Del Norte Consortium  
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## APPLICATION FOR CME APPROVAL/PLANNING PROCESS

**TITLE:** \_\_\_\_\_

**NAME OF FACULTY(S)**

**TITLE OR POSITION**

\_\_\_\_\_

\_\_\_\_\_

**ADDRESS**

**PHONE AND FAX NUMBER**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FED TAX ID # OF SPEAKER**

\_\_\_\_\_

**DATE/TIME/LOCATION:** \_\_\_\_\_

**SUPPORTING COMPANY:** \_\_\_\_\_

**CONTACT NAME** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

**LIVE ACTIVITIES:**  Course (symposium, conference, grand rounds)  RSS  Internet Live

**ENDURING MATERIALS:**  Committee Learning  Journal Based  Performance Improvement

**JOINT PROVIDED ACTIVITY:**  Yes  No

**PLANNER/PRESENTER/DISCLOSURES:** (List all involved in the planning of this activity)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PROFESSIONAL PRACTICE GAP (PPG):** Describe at least one PPG for your target audience that is the difference between current practice or outcomes and desirable or achievable practice or outcomes.

*List the source(s) that are used to define the gap(s).*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HOW DO WE PLAN TO IMPROVE THE EDUCATION GAP (NEED):** Identify one or more educational needs that, if met, may help to close the gap.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**TYPE OF EDUCATION GAP (NEED):** For each need, determine if it is due to a lack of knowledge, competence and/or performance.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**EXPECTED RESULTS:** The intended result of this activity is a change in:

- Competence (New or improved skills or strategies that are intended to be put into practice)
- Performance (New or improved skills and strategies that are implemented in practice)
- Patient Outcomes (Analysis of data pre/post activity)

**COURSE OBJECTIVES:**

By the end of this activity, participants will be able to:

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

**EDUCATION METHODS:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Didactic Lecture | <input type="checkbox"/> Panel Discussion  | <input type="checkbox"/> Round Table Discussion |
| <input type="checkbox"/> Q & A Session    | <input type="checkbox"/> Case Presentation | <input type="checkbox"/> Simulation/Skills Lab  |

**WHAT IS THE PHYSICIAN TARGET AUDIENCE:**

\_\_\_\_\_

**WHAT IS THE DESIRABLE PHYSICIAN ATTRIBUTE:** Check one or more attributes/core competency relevant to the target audience for this activity.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Patient care or patient-centered care   | <input type="checkbox"/> Professionalism/Ethics                 | <input type="checkbox"/> Quality Improvement |
| <input type="checkbox"/> Medical knowledge                       | <input type="checkbox"/> Utilization of informatics             | <input type="checkbox"/> System-based        |
| <input type="checkbox"/> Practice-based learning and improvement | <input type="checkbox"/> Interdisciplinary teams                |  |
| <input type="checkbox"/> Employment of evidence-based practice   | <input type="checkbox"/> Interpersonal and communication skills |  |

**CULTURAL & LINGUISTIC COMPETENCY (CLC):** If an activity has a clinical care component, the planners (not faculty or authors) must identify as part of their planning process at least one cultural or linguistic health disparity that is relevant to the targeted physician learners or their patient community. The provider should document when no CLC issues was identified. For each relevant disparity, indicate how it will be addressed in the activity (e.g., presentation slides, handout material, etc.)

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

**METHODS TO MEASURE CHANGES IN LEARNERS' COMPETENCE OR PERFORMANCE, OR IN PATIENT OUTCOMES:**

**Competence:**

- |   |   |
|---|---|
| <input type="checkbox"/> Learner Evaluation Form      | <input type="checkbox"/> Case-based Studies (where learner must make decisions) |
| <input type="checkbox"/> Customized pre and post test |   |

**Performance:**

- |  |   |
|--|---|
| <input type="checkbox"/> Customize follow-up surveys | <input type="checkbox"/> Measure adherence to best practices/guidelines |
|--|---|

**Patient Outcomes:**

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Observation | <input type="checkbox"/> Patient feedback and surveys |
| <input type="checkbox"/> Data        | <input type="checkbox"/> Other, specify _____         |

**APPLICATION SUBMITTED BY:**

NAME _____	DATE _____
TITLE _____	PHONE _____

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**FOR OFFICE USE ONLY**

APPLICATION FEE: \_\_\_\_\_ \$500.00 GRAND ROUND/NON-GRAND ROUND  
                                  \_\_\_\_\_ \$500.00 APPLICATION FEE & \$250.00 A/V RENTAL  
                                  \_\_\_\_\_ \$500.00 ANNUAL APPLICATION FEE  
                                  \_\_\_\_\_ FEE WAIVED

CONSORTIUM COMMITTEE MEMBER: (Print) \_\_\_\_\_

CONSORTIUM COMMITTEE MEMBER: (Signature) \_\_\_\_\_

DATE OF APPROVAL \_\_\_\_\_

APPROVED FOR \_\_\_\_\_ HOURS AMA PRA CAT 1 CME CREDITS™

**Analysis of Activity (Data from Evaluation Forms):**

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