



UNIVERSITY OF  
NEW ENGLAND  
College of Osteopathic Medicine

University of New England College of Osteopathic Medicine  
Department of Continuing Medical and Professional Education

**JOINT SPONSORSHIP/CME ACCREDITATION APPLICATION**

Date Application Submitted \_\_\_\_\_ Date Application Received (for office use) \_\_\_\_\_

Title of Activity: \_\_\_\_\_

Activity Date(s): \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Sponsoring Organization: \_\_\_\_\_

(check one if applicable):  Non-AOA Accredited Institution/Hospital  Accredited AOA Institution/Hospital

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact email: \_\_\_\_\_

**Planning Committee Structure:**

In addition to the above individuals, list all persons responsible for planning, designing, developing, and implementing this CME activity. Include names, degrees, titles, and affiliations. [Note: No employee of a commercial interest may serve on the planning committee nor be allowed to influence educational content (nuanced or direct).]

Name:	Title/Affiliation:
Name:	Title/Affiliation:
Name:	Title/Affiliation:
Name:	Title/Affiliation:

CME Requested:  AOA  ACCME  AAFP  Other (specify): \_\_\_\_\_

(Note: All activities approved for CME will automatically be awarded UNE contact hours)

# of hours anticipated: \_\_\_\_\_ Anticipated Attendance \_\_\_\_\_

Program Type:  Formal live activity (lecture, course, symposium, seminar, workshop)

Study Group

Enduring Materials – on-line CME

**RSS (Regularly Scheduled Series – i.e. Grand Rounds)**

Other (specify): \_\_\_\_\_

Target Audience:  MD/DO  RN  APRN/NP  PA  Other (specify): \_\_\_\_\_

Educational formats to be used (check all that apply):

Small group discussion/panel

Chart review / Recall

Case presentations

Q&A

Hands-on practice

Videotape

Lecture

Web content/activity

Other: \_\_\_\_\_

Anticipated Registration Fee \$ \_\_\_\_\_ (if multiple fees, list all) \_\_\_\_\_

Will the course or event receive commercial support? \_\_\_ Yes \_\_\_ No

If yes, list name(s) of commercial support organizations (use another sheet if necessary)

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## Documenting the Need

Please briefly explain what gaps in knowledge and/or performance contributed to determining a **need** for the program's topic(s)

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1. What data do you have that supports this need (attach)?	<input type="checkbox"/> Quality improvement or performance data <input type="checkbox"/> Potential participant's request <input type="checkbox"/> Organizational mandate or new initiative <input type="checkbox"/> Emerging clinical guidelines or new technology <input type="checkbox"/> Accrediting body requirement <input type="checkbox"/> AOA/ABMS/ACGME competencies that need to be addressed <input type="checkbox"/> Other. Please explain:
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How will this educational activity address this need? (Check all that apply)	It will impart: <input type="checkbox"/> <b>Knowledge:</b> <i>No activity will be approved that provides ONLY knowledge. While the activity can impart knowledge, it must <u>also</u> address Competency or Performance</i> <input type="checkbox"/> <b>Competency:</b> The activity provides knowledge AND the <i>process, strategy, or tools</i> to apply that knowledge <sup>i</sup> <input type="checkbox"/> <b>Performance:</b> The activity arises out of performance or quality improvement data, examines current clinical practice performance and measures it against established guidelines, newly developed or adopted performance standards, or previous performance data <sup>ii</sup>
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All Continuing Medical Education is required to contribute to physician competency. The following is a list of AOA/ABMS/ACGME Physician Competencies. Please check those that would be addressed in this activity.	<input type="checkbox"/> Patient care <sup>iii</sup> <input type="checkbox"/> Practice-based learning and improvement <sup>iv</sup> <input type="checkbox"/> Interpersonal and communication skills <sup>v</sup> <input type="checkbox"/> Professionalism <sup>vi</sup> <input type="checkbox"/> Medical Knowledge <sup>vii</sup> <input type="checkbox"/> Systems-based practice <sup>viii</sup> <input type="checkbox"/> Osteopathic philosophy and osteopathic manipulative medicine
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## Learning Objectives

What will you look for (in competency, performance, or patient outcomes) that will indicate this activity has been successful?	
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How and when will you measure this expected outcome?	
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Please translate these desired outcomes into 2-5 learning objectives for the activity:	<i>As a result of participating in this activity, the attendee should be able to.....</i> 1)  2)  3)  4)  5)
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Provide a brief **Overview** of the program:

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If an RSS (i.e. Grand Rounds): Identify person(s) responsible for **monitoring** the sessions/series for compliance with ACCME and AOA regulations for RSS.

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If an RSS: How will the organization evaluate the success of the program/series in increasing knowledge and/or performance of participants?

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**Required documentation to accompany this application:**

1. Draft or preliminary agenda, including
  - Topics or presentation titles
  - Names and credentials of all presenters (necessary to determine CME category)

- Start and finish times for all talks, breaks, lunches, etc., if applicable
2. Needs Assessment Documentation (The need for the program was derived from what data, i.e. source data, evidence based data, survey results, practice gap analysis, etc...)
  3. Draft or actual copies of promotional materials, including web content, invitations, letters et al.
  4. If RSS, (i.e. Grand Rounds) presentation titles, names and credentials of all presenters attached for at least the first quarter of the year, and subsequently quarterly throughout the year.

**Note:** all final promotional materials must contain the accepted accreditation language provided by UNE application approval. *Under no circumstances may a brochure or flyer state "CME anticipated" or "CME applied for."* The only exception to this is a *Save the Date card, which may state that CME will be offered and/or is anticipated.*

**The application will not be considered, nor will CME credit be determined or awarded, until the CME office receives all of the required documentation.**

**Forward completed form, along with required documentation to:**

Doreen Fournier Merrill, M.S.W., Director  
 UNE – Department of Continuing Medical & Professional Education  
 11 Hills Beach Road  
 Biddeford, Maine 04005  
 FAX: 207-602-5957  
 Email: [dmerrill3@une.edu](mailto:dmerrill3@une.edu)

<b>OFFICE USE ONLY</b> <input type="checkbox"/> Formal Live <input type="checkbox"/> EM <input type="checkbox"/> SG <input type="checkbox"/> RSS <input type="checkbox"/> Series
Date Received: _____ Office Manager Initial: _____
CME Director Initial: _____ Date Reviewed: _____
Physician Review/Approval: _____ Date Approved: _____
AAFP Physician Review/Approval: _____ Date Approved: _____
Approved for: _____ AOA Category _____ credits;            _____ AMA PRA Category _____ Credit(s) <sup>TM</sup> ;
(apply for) _____ AAFP credits;            _____ UNE Contact Hours. Other: _____
Disapproved ( <i>description</i> ): _____

(2/19/14)