

***FORM CMERSS-3***

**RSS RENEWAL APPLICATION CHECKLIST AND FORM**

**July 1, 2020 – June 30, 2021**

**DUE ON JULY 15, 2020**

The following are required documentation for all WCM RSS Activities for July 1, 2020 to June 30, 2021.

Attachments

1. Completed and signed Renewal Application *(Form CMERSS-3)*  Yes  No
2. Full Disclosure Forms *(Form CME-A)*  Yes  No

*For Course Directors and/or Course Co-Directors, Planners, Coordinator*

*and First Presenter*

3. If applicable, Course Director/ICR Documentation of COI  Yes  No

Resolution Forms *(Form CME-B)*

*For Course Director and/or Course Co-Director, Planners, Coordinator*

*and First Presenter*

4. a. Sample CME Information Page for first session *(Form CMERSS-4)*  Yes  No

b. Full Disclosure Form(s) for first session *(Form CME-A)*  Yes  No

5. Sample Evaluation Form *(Form CMERSS-5)*   Yes  No

*Made specific to the course*

6. Tentative list of Planned Sessions/Topics  Yes  No

7. Needs Assessment Documentation  Yes  No

*Both Quality Improvement/Audit data (a letter from the Course Direction attesting*

*to the utilization of QA data in the planning of the education content of the activity*

*would suffice) and a recent article from a peer review journal demonstrating the*

*gap in knowledge, competence or performance that will be addressed are required.*

***FORM CMERSS-3***

**Course #:** \_\_\_\_\_\_\_\_\_\_\_*(to be assigned by CME Office)*

REGULARLY SCHEDULED SERIES RENEWAL APPLICATION FOR AY 2020-2021

**An electronic copy of this renewal application along with all required attachments must be submitted by July 15, 2020.**

***(We may request a hard copy at a later date).***

This form may be used annually to renew approved ongoing Weill Cornell CME activities. No activities can be renewed without successful completion of previous year data. A new application in its entirety will be required periodically. Unless otherwise noted in this renewal application, all data from previous applications will be considered unchanged. Thank you for contributing to the overall program of CME at Weill Cornell. The Office of CME is available to assist with the completion of this form. Please contact the Office of CME at 646-962-6931 or [cme@med.cornell.edu](mailto:cme@med.cornell.edu) for additional information.

**GENERAL INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Activity Information** | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **Activity Name** | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Department:** | | | | | | | **Division:** | | | | | | | | | | | | **Activity Location:** | | | | | | | | |
| **Dates** | | | July 1, 2020 –  June 30, 2021 | | | **# of AMA/PRA Category 1 Credits requested per session** | | | | | | | | |  | | | | | | **Estimated # of participants per session** | | | | | |  |
| **Educational Format** | | | Grand Rounds Tumor Board Journal Club Morbidity and Mortality Conference  Other, please specify: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Frequency of lectures** | | | Weekly Bi-Weekly Monthly Other *(please specify):* | | | | | | | | | | | | | | | | | | | | | | | | |
| **Day of Week** | | | M T W TH F | | | | | | | | | From \_\_\_:\_\_\_ AM PM To**\_\_\_:\_\_\_** AM PM | | | | | | | | | | | | | | | |
| **Course Director:** *A Cornell faculty member who will assume overall responsibility for planning, developing, implementing, and evaluating the content and logistics of the activity. If the Course Director has ANY relationships with commercial interests, a Course Co-Director must be designated for this activity. The Course Co-Director must be free of relationships with commercial interests.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | | | **Degree(s)** | | | | | | | | | **Full Disclosure Form attached?** Yes No | | | | | | | |
| **Title** |  | | | **Affiliation** | | | |  | | | | | | **Department** | | |  | | | | | | | | | | |
| **Address** |  | | | | | | | **City** | | |  | | | **State** | | | |  | | | | | | | **ZIP** |  | |
| **Phone** |  | | | **Fax** | | | |  | | | | | | **Email** | | | |  | | | | | | | | | |
| **Course Co-Director *(where applicable)*:** *A Cornell faculty member who shares responsibility for planning the activity.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | | | **Degree(s)** | | | | | | | | | **Full Disclosure Form attached?** Yes No | | | | | | | |
| **Title** |  | | | **Affiliation** | | | |  | | | | | | **Department** | | | |  | | | | | | | | | |
| **Address** |  | | | | | | | **City** | | |  | | | **State** | | | |  | | | | | | | **ZIP** |  | |
| **Phone** |  | | | **Fax** | | | |  | | | | | | **Email** | | | |  | | | | | | | | | |
| **Course Coordinator** *The individual responsible for the operational and administrative support of the activity. This may be an administrative staff in the Department.* **Any changes in staffing for this activity? Yes No (*If new, a training session with the CME Staff is required)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | | | **Degree(s)** | | | | | | | | | **Full Disclosure Form attached?** Yes No | | | | | | | |
| **Title** |  | | | **Affiliation** | | | | |  | | | | **Department** | | | |  | | | | | | | | | | |
| **Address** |  | | | | | | | | **City** | |  | | **State** | | | | | | | | |  | | **ZIP** | |  | |
| **Phone** |  | | | **Fax** | | | | |  | | | | **Email** | | | | | | | | |  | | | | | |
| **Planning Committee *In addition to the Course Director, Course Co-Director, and/or CME coordinator****, 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.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | | | **Degree(s)** | | | | | | | | | **Full Disclosure Form attached?** Yes No | | | | | | | |
| **Title** | |  | | | **Affiliation** | | | | | |  | | | | | **Email** | | | | | | |  | | | | |
| **Name** | | | | | | | | | | | **Degree(s)** | | | | | | | | | **Full Disclosure Form attached?** Yes No | | | | | | | |
| **Title** | |  | | | **Affiliation** | | | | | |  | | | | | **Email** | | | | | | |  | | | | |
| **Name** | | | | | | | | | | | **Degree(s)** | | | | | | | | | **Full Disclosure Form attached?** Yes No | | | | | | | |
| **Title** | |  | | | **Affiliation** | | | | | |  | | | | | **Email** | | | | | | |  | | | | |

I attest that no employees or representatives of pharmaceutical companies, medical device manufacturers, or other ACCME-defined commercial interests were involved in the identification of planners, speakers, or topics.

***List of additional planning committee members attached***

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| **Targeted Audience** *(select all that apply – at least 1 box from audience type, geographic location, and specialty must be selected) C4* |
| *CME* *activities should promote improvements in multidisciplinary patient*  *care. Please check all groups for whom this activity would be appropriate:*   |  |  |  |  | | --- | --- | --- | --- | | **Audience (Select 2 or more):**  Physicians  Medical Students  Graduate House staff  Psychologists  Physician Assistants  Nurses  Nurse Practitioners  Medical Students  Social Workers  Physical Therapists  Pharmacists  Patients  Nutritionists  Public Health Professionals  Other (specify):  **Please initial here that we may promote this activity to these other professionals. \_\_\_\_\_\_\_\_\_\_\_(initial here)** | **Geographic Location:**  Internal (WCM/NYPH)  Local/Regional  National  International | **Specialty:**  All Specialties  Anesthesiology  Cardiology  Dermatology  Emergency Medicine  Family Medicine  General Medicine  Neurology  OB/GYN  Oncology  Orthopaedics  Pediatrics  Primary Care  Psychiatry/Psychology  Radiology  Radiation Oncology  Surgery  Other (specify): |  | |

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| **INTERPROFESSIONAL CME - PLANNERS**  As per new ACCME guidelines, whenever possible members  of interprofessional teams should be engaged in the **planning**  of CME activities that are intended to improve interprofessional clinical care. Please indicate which professions were involved as planners in this activity (**Select 2 or more**):  Physicians  Medical Students  Graduate House staff  Psychologists  Physician Assistants  Nurses  Nurse Practitioners  Medical Students  Social Workers  Physical Therapists  Pharmacists  Patients  Nutritionists  Public health Professionals  Other (specify): | **INTERPROFESSIONAL CME - EDUCATORS**  As per new ACCME guidelines, whenever possible members of interprofessional teams should be engaged in the **delivery** of CME activities. Please indicate which professions will be involved as teachers or educators at this activity (**Select 2 or more**):  Physicians  Medical Students  Graduate House staff  Psychologists  Physician Assistants  Nurses  Nurse Practitioners  Medical Students  Social Workers  Physical Therapists  Pharmacists  Patients  Nutritionists  Public health Professionals  Other (specify): |

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| **Core Competencies (select 3 at minimum)**  *CME activities should be developed in the context of desirable physician attributes. Please indicate which American Board of Medical Specialties (ABMS)/Accreditation Council for Graduate Medical Education (ACGME), Institute of Medicine (IOM) core competencies or Interprofessional Education Collaborative will be addressed in this activity.* |
| *Patient Care and Procedural Skills:*Provide care that is compassionate, appropriate, and effective treatment for health problems and to promote health.  *Medical Knowledge:*Demonstrate knowledge aboutestablished and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of this knowledge to patient care.  *Practice-Based Learning and Improvement:*involves investigation and evaluation of their own patient care practices, appraisal and assimilation of scientific evidence, and improvements in patient care.  *Interpersonal and Communication Skills:* Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates.  *Professionalism*: Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.  *System-Based Practice:*actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.  *Provide Patient-centered care:*Identify, respect, and care about patients’ differences, values, preferences, and expressed needs; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.  *Work in Interdisciplinary Teams:*Cooperate, collaborate, communicate and integrate care teams to ensure that care is continuous and reliable.  *Employ evidence-based practice:* Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.  *Apply Quality Improvement:* Identify errors and hazards in care: understand and implement basic safety design principles such as standardization and implications; continually understand and measure quality of care in terms of structure, process and outcomes in needs; and design and test interventions to change processes and systems of care, with the objective of improving quality.  *Utilize Informatics:*Communicate, manage knowledge, mitigate error, and support decisions making using information technology.  *Values/Ethics for Interprofessional Practice:*Work with individuals of other professions to maintain a climate of mutual respect and shared values.  *Roles/Responsibilities:*Use the knowledge of one’s own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.  *Interprofessional Communication:*Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.  *Teams and Teamwork:*Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable.  *Other Competencies:*Specify |

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| **Needs Assessment Data and Sources (select at least 2 – QA and a recent article from a peer review journal at a minimum)**  *Please indicate the sources used to identify the deficiencies/quality gaps or needs.* ***Check all that apply and PROVIDE SUPPORTIVE DOCUMENTATION for each of the selected sources.*** *C2* | |
| Quality assurance/audit data ***(required for all RSS)***  A recent article from a peer review journal demonstrating the gap in knowledge, competence or performance that will be addressed in this activity ***(required for all courses)***  Previous Participant Evaluation Summaries  New methods of diagnosis or treatment  Availability of new medication(s) or indications(s)  Development of new technology  Input from experts regarding advances in medical knowledge (other than course director)  Literature review  Data from outside sources, e.g., public health statistics, epidemiological data | Survey of target audience  Professional society requirements  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).  Continuing review of changes in quality of care as revealed by medical audit or other patient care reviews  Mortality/Morbidity Data  Legislative, regulatory or organizational changes effecting patient care  Joint Commission Patient Safety Goal/Competency:  Specialty Society Guidelines  Other: |

| Educational Design/Methodology *The activity should be structured to achieve the stated learning objectives. Please indicate the educational method(s) that will be used to achieve the stated objectives. Activities that are solely lectured-based are strongly discouraged. Select all that apply (a minimum of 3 is required). C5* | | |
| --- | --- | --- |
| TEACHING MODE Please choose at least **3** of the following: | TYPE OF EDUCATIONAL OBJECTIVE ADDRESSED | |
|  | KNOWLEDGE | **SKILLS** |
| Lectures |  |  |
| Case-based Presentations |  |  |
| Workshops |  |  |
| Panel Discussion |  |  |
| Small Group Discussion |  |  |
| Questions & Answers |  |  |
| Video or Audio Presentations |  |  |
| Hands-On Lab/Skills Training |  |  |
| Formal Discussion Groups |  |  |
| Self-Assessment Inventory |  |  |
| Skill-Based Training Sessions |  |  |
| Computer Programs |  |  |
| Mini-Residencies/Fellowships |  |  |
| Teleconferencing |  |  |
| Simulations (e.g., role play) |  |  |
| Readings |  |  |
| Journal Club |  |  |
| Web-based Interactive Learning |  |  |
| Other: |  |  |

Explain why this educational format is appropriate for this activity?       (max. 25 words)

**ACTIVITY PLANNING**

Please review your activity planning and respond to the following questions.

1. **Multidisciplinary Education (C23):**
2. Is this activity ***planned*** by a multidisciplinary team?  Yes  No

Please list the non-MD team members involved in planning:

2. Will this activity be ***attended*** by health care professionals other than MD’s?  Yes  No

Please provide a list of types of other providers that will attend:

3. Will non-MD health care professionals participate in the ***teaching*** of this activity?

(e.g. Ph.D., RN, NP, Social Worker, other related professional)  Yes  No

Please provide a list of sessions that will be taught by non-MD professionals:

**B.  Education for Students of the Health Professions (C25):**

1. Will medical students, residents, fellows, or other health care students be involved in the **planning** of this activity? Yes  No

If so, please list any trainees that will be involved:

1. Will any sessions in this activity be **TAUGHT** by trainees (any students/learners within the health care professions)? (This can include a case presentation by a student)  Yes  No

Please list those sessions which fulfill this criteria:

1. Will trainees (any students of the health care professions) **attend** this activity?    Yes  No

If so, please describe:

**C.  CME activities are required to demonstrate that they have used health and practice data for healthcare improvement (C26, C37):**

1. Please list any parts of this activity that will use Quality Improvement and Patient Safety Data in the planning, and that will be designed to address this need. (***At least 2 sessions directly related to QA & Patient Safety are required by the WCM CME Committee)***

1. Will any studies or observations be done to demonstrate that this leads to improved patient care?

1. Will any additional strategies be used outside of this activity to reinforce this? (e.g. signage, EMR changes, follow-up e-mails, notices)

**D.  CME should lead to improved Communication Skills (C29):**

Will this activity include any focus upon patient or interprofessional communication skills?  Yes  No

If so, please list any sessions that will incorporate this:

**E.  Optimization of Technical and Procedural Skills (C30):**

Will any of the sessions of this activity specifically focus on learning technical or procedural skills in patient care?    Yes  No

If so, please list:

**F.   Creative Educational Formats (C35):**

CME programs are encouraged to move away from standard lecture formats in teaching healthcare professionals.

Will this course be presented in a traditional lecture format?  Yes  No

1. If **YES**, please describe:

2. If **NO**, please describe the educational format (e.g., workshops, skills training):

| **Identification of Professional Practice Gaps, Educational Needs, Desired Results, Learning Objectives, and Outcomes**  Using the data above, all CME activities should be derived from a set of Identified Needs and should be presented with a clearly delineated set of learning objectives and desired outcomes. ***Select all that apply.*** *C2,3,11* |
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| **Professional Practice Gap:** *State the professional practice gap of the learners on which this RSS is based (maximum 100 words) (C2)* |
|  |

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| **Educational Need:** *State the educational need(s) that you determined to be the cause of the professional practice gap(s)* |
| **Knowledge need:**       (max. 50 words)    **Competence need:**       (max. 50 words)  **Performance need:**       (max. 50 words) |
| **Change:** *State what this RSS was designed to change in terms of learners’ competence or performance or patient outcomes* |
| 1. What is this RSS designed to change in terms of learner’s competence and/or performance?       (max. 50 words)  2. What improvements in patient care is this RSS designed to change?       (max. 50 words) |

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| **Objectives/Desired Outcomes (Results)**  *Please state, in words to be used on printed materials, the Objectives for this activity (These should be stated in terms that will allow you to measure if changes in knowledge, competence, performance or patient outcomes have occurred?). Objectives should be framed in terms of “What” participants can expect to learn or implement based upon their participation. C11.* |
| By the conclusion of this activity, participants should be able to:  a.  b.  c.  d. |

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| **II. Outcomes** |
| In addition to standard evaluation procedures, the WCM CME Committee may require the Course Director of any activity to conduct a study of the outcome of any CME activity on patient care. If so, the Office of CME will collaborate with you to design this research.  The need for a post-course Outcomes Study will be decided by the Committee on an activity-by-activity basis as part of the review process. It will likely be required for repeated one-time activities, or on those one-time activities that receive industry support.  You will be notified of this at the time of this application’s review.  *Please attest to the following statement by checking the box below* ***(RESPONSE REQUIRED):***  I understand that I may be required to conduct an outcomes study as a condition of approval of this activity by Weill Cornell Medical College as part of its overall CME program. |

**ESTIMATED BUDGET (July 1, 2020 – June 30, 2021)**

WCM Honoraria and Expense Policy can be found at <http://weill.cornell.edu/education/programs/con_cme_gui.html>

|  |  |
| --- | --- |
| **Income Category** | **Budget** |
| Weill Cornell Department Funding |  |
| Other Funding       ***(No Industry Support is allowed)*** |  |
| **Total Income** | **$-** |
| **Expense Category** |  |
| **Honoraria (list for each speaker)** |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Subtotal - Honoraria** | **$-** |
| Faculty Housing |  |
| Travel Expenses |  |
| Meals |  |
| Supplies |  |
| Room Rental |  |
| A/V Rental |  |
| Other *(describe)* | **$-** |
| **Total Expense\*** | **$** |
| **Net Gain/Loss:** *(total income minus total expenses)****\*\**** | **$-** |

* *Expenses must be offset by either Departmental or other income*
* *\*\* Negative balances are not acceptable*

*Please note that Regularly Scheduled Series are not permitted to accept industry support. For any support other than Departmental funds, please contact the CME Office in order to obtain the approval of the CME Committee prior to the presentation.*

**In compliance with our Honoraria and Expense Reimbursement Policy, all expenses must be paid from a Weill Cornell Account.**

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| **Honoraria** will be paid to speakers from the following Weill Cornell Account: |  |
| **Income** from this course will be deposited to the following Weill Cornell Account: |  |
| **Deficits** and all CME related fees for this activity will be the responsibility of the  Department and the following Weill Cornell account will be debited: |  |

**ADDITIONAL RSS INFORMATION**

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| **ACADEMIC PROGRAM AND CME INFORMATION PAGE** *(All materials must be approved by the CME Office prior to distribution. A sample copy is on our website,* [*http://cme.med.cornell.edu*](http://cme.med.cornell.edu)*, under Regularly Scheduled Series)* |

The CME Information Page is a summary of CME information that must be handed out to participants or posted at your activity. This Information Page includes: Identified Practice Gaps/Educational Needs, Targeted Audience, Course Objectives/Desired Outcomes, Disclosure of Relationships/off-label statements/Content Validation Statement, Full Disclosure Information for all participants, Accreditation Statement, Credit Designation Statement, Course Evaluation Information and a statement offering to accommodate those with special needs.

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| **INTELLECTUAL PROPERTY POLICY AND HIPAA** |

In accordance with Cornell and Medical College policies: (i) copyrights arising from educational and related enduring materials developed in any media for CME programs and presentations vest ownership in the author of such materials; (ii) such materials shall be made available on a continuing basis for education and teaching purposes by faculty and academic staff of WMC; and (iii) any use of the names of the University, the Medical College, the WCM CME Office, or the names of any member of the faculty or staff of Cornell or WMC for commercial endorsements, advertising or similar publicity purposes is prohibited without the prior written permission of the Dean of the Medical College and University Counsel (as recommended in the discretion by the WCM CME Office). The WCM CME Office is available to assist CME planners and sponsors in the appropriate usage of copyrightable materials in accordance with Cornell and Medical College policies and procedures. Also, in accordance with HIPAA and privacy law, images of patients should not be used in presentation materials unless a release by the subject or his or her bona fide representative is attached to this application.

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| **FINAL SUMMARY** |

Final CME certificates will not be issued until the Course Director has submitted all the required reports for the activity. Reports must include attendance lists **(attendee lists are considered confidential and cannot be shared with other organizations or industry supporters without written approval of the CME Office)**, a summary of the results of post-activity evaluations, final financial report, CME information pages, Full Disclosure Forms and CD/ICR COI Resolution Forms (if applicable). In addition, activity files and attendance records must be maintained for six years after the date of the activity.

**ATTESTATIONS**

*Based on new and current guidelines from the ACCME please attest to the following statements by checking the boxes below:*

|  |
| --- |
| ***NYP/WCM Quality Assurance/Patient Safety Data and Previous Course Evaluations*** |
| I verify that NYP/WCM Quality Assurance/Patient Safety data was used to identify deficiencies/quality gaps or needs for this activity. I verify that an assessment of Quality and Patient safety needs has been performed and that the curriculum for this activity includes activities aimed at addressing deficiencies and closing quality gaps.  I verify that I have obtained and incorporated identified Quality Improvement/Patient Safety issues and previous participant evaluations into the curriculum for this activity*.*  Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Definition of CME*** |
| All activities must meet the definition of continuing medical education put forth by the ACCME and the AMA: *“Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.”*  Indicate below that you have read the Definition of CME and that the proposed activity meets the Definition.  This activity meets the Definition of CME Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Weill Cornell Medical College CME Mission*** |
| All activities must support the CME Mission of Weill Cornell Medical College. Please click on the following link to read the CME Mission Statement: <http://weill.cornell.edu/education/programs/con_mis_sta.html>. Indicate below that you have read the WCM Mission Statement and that the proposed activity meets the Definition.  This activity supports Weill Cornell Medical Mission. Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_ |
| ***Content Validation*** |
| WCM is responsible for validating the clinical content of CME activities that they provide. Please specify that:  All the recommendations involving clinical medicine in this CME activity are based on evidence that is accepted within the  profession of medicine as adequate justification for their indications and contraindications in the care of patients.  All scientific research referred to, reported or used in this CME activity in support or justification of a patient care  recommendation conforms to the generally accepted standards of experimental design, data collection and analysis.  Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Engagement with Clinical Environment*** |
| I understand that I must include QA/UR and Patient Safety data/hospital initiatives into the planning of this activity as requested.  I attest that at least 2 sessions directly related to Quality Assurance and Patient Safety issues will be included in this RSS during this reporting year. I verify that an assessment of Quality and Patient Safety needs will be performed and that the curriculum of this activity includes activities aimed at addressing deficiencies and closing quality gaps.  I understand that I may be required to conduct or participate in an outcomes study as a condition of approval of this activity by Weill Cornell Medical College or NYP-WCM as part of its overall CME program.  Where applicable, I agree to use a portion of the educational program of this activity for Quality Improvement and Patient Safety concerns as identified by the Office of CME or NYP-WCM Quality Patient Safety  Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Clinical Needs/Outcomes Study*** |
| In addition to standard evaluation procedures, the WCM CME Committee or NYP-WCM may require the Course Director of any activity to conduct a study of the outcome of any CME activity on patient care. If so, the Office of CME will collaborate with you to design this research. The need for a post-course Outcomes Study will be decided by the Committee on an activity-by-activity basis as part of the review process.  Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Commercial Support/Interests*** |
| WCM does not accept commercial support for any Regularly Scheduled Series.  I attest that no employees or representatives of pharmaceutical companies, medical device manufacturers, or other ACCME-defined commercial interests were involved in the identification of planners, speakers, or topics.  Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Site Visits*** |
| The CME Committee reserves the right to send a representative to CME activities in order to evaluate the activity and its content. Periodic site visits by a member of the CME Staff may also occur.  Course Director ***(Please initial)*** \_\_\_\_\_\_\_\_\_\_\_\_ |

**SIGNATURES**

Please provide signatures below indicating acceptance of the following terms and conditions for providership by Weill Cornell Medical College. To ensure final designation of credit, each Course Director agrees to collaborate with the Office of CME to ensure that the planning and implementation of the proposed CME activity are consistent with the policies and procedures of WCM and the ACCME.

You must keep all documents associated with this activity, including attendance records, evaluations, Full Disclosure Forms and CME Information Pages, for all sessions for **6 years**. These documents must be available upon request from the CME Office.

**THIS APPLICATION, ATTESTATIONS AND BUDGET HAVE BEEN REVIEWED AND APPROVED BY:**

**COURSE DIRECTOR:**

I certify that this application was completed accurately and attest to the validity of the information contained in the application. I have read and agree to abide by the *Weill Cornell and ACCME guidelines, including Standards for Commercial Support* [ACCME Standards for Commercial Support. If there are changes in these guidelines subsequent to this activity’s approval I agree to make any and all necessary changes to this activity.](http://www.accme.org/dir_docs/doc_upload/68b2902a-fb73-44d1-8725-80a1504e520c_uploaddocument.pdf)

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

Print Name (Course Director)

|  |  |  |
| --- | --- | --- |
| **X** |  |  |

Signature Date

**COURSE CO-DIRECTOR: (if applicable)**

I certify that this application was completed accurately and attest to the validity of the information contained in the application. I have read and agree to abide by the *Weill Cornell and ACCME guidelines, including Standards for Commercial Support* [ACCME Standards for Commercial Support. If there are changes in these guidelines subsequent to this activity’s approval I agree to make any and all necessary changes to this activity.](http://www.accme.org/dir_docs/doc_upload/68b2902a-fb73-44d1-8725-80a1504e520c_uploaddocument.pdf)

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

Print Name (Course Co-Director)

|  |  |  |
| --- | --- | --- |
| **X** |  |  |

Signature Date

**WEILL CORNELL DEPARTMENT CHAIR:**

I have reviewed this application, approve of its content and budget, and agree to oversee this as an educational activity in

my department.

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

Print Name (Department Chair)

|  |  |  |
| --- | --- | --- |
| **X** |  |  |

Signature Date

**APPENDIX 1**

Full Disclosure Forms *(Form CME-A)*

Please attach here

**APPENDIX 2**

(If applicable) Course Director/ICR Documentation of Conflict of Interest (COI) Resolution Forms *(Form CME-B)*

Please attach here

**APPENDIX 3**

Sample CME Information Page for first session (Form CMERSS-4)

Full Disclosure Form(s) for first session (Form CME-A)

Please attach here

**APPENDIX 4**

Sample Evaluation Form *(Form CMERSS-5)*

Please attach here

**APPENDIX 5**

Tentative list of Planned Sessions/Topics

Please attach here