McMaster University, Faculty of Health Sciences
Continuing Health Sciences Education Program
www.fhs.mcmaster.ca/conted

1280 Main Street West
MDCL, Rm 3510
Hamilton, ON, Canada L8S 4K1

Phone: 905-525-9140 x22120
Fax: 905-572-7099
Email: laffans@mcmaster.ca

APPLICATION FOR PROGRAM ACCREDITATION

Complete and print this fillable online PDF form, or print this form and complete by hand.
Submit completed form with ALL supporting documents to the attention of the Program Manager, CHSE Office:
by fax, in person, or by mail **at least four weeks prior to your program.**
Expedited applications will be subject to additional fees.

A non-refundable processing fee will be charged for application review.

Date of Application: YEAR ☐☐☐☐ MONTH ☐☐ DAY ☐☐

This program is a McMaster University Faculty of Health Sciences Event: ☐ Yes ☐ No

Is this program being co-developed? ☐ Yes ☐ No

If yes, specify co-developer: _____

Is this program being co-sponsored with another Non FHS partner? ☐ Yes ☐ No

If yes, specify co-sponsor: _____

Program Name: _____

Program Date(s) and Time(s): _____

Program Location (Institution/Resort/Hotel/City/Province): _____

_____

Indicate the credit categories required for the target audience (check all that apply):

- ☐ The College of Family Physicians of Canada Main Pro M1*
- ☐ The Royal College of Physicians and Surgeons of Canada MOC Credit* (choose one of the following):
  - ☐ MOC Section 1
  - ☐ MOC Section 3, Simulation
  - ☐ MOC Section 3, Self Assessment (Additional RC form must be completed and attached with application)

***Note: Planning Committee Membership must include an Active Member of the Colleges for respective categories requested.**

Section A: Please provide the following information about the program:

Type of the Program:

☐ Conference	☐ Rounds	☐ E-learning	☐ Simulation
☐ Workshop	☐ Journal Club	☐ Seminar Series	☐ Self-Assessment Tool
☐ PBSG	☐ Other, Please specify: _____		

Planning Committee Chair/Course Director: _____

Institution / Organization: _____

Discipline: _____

Street/City: _____

Province: _____ Postal Code: _____

Telephone: _____ Fax: _____

Email: _____

Academic Chair/Assistant or Associate Dean/Director or Designate (Required for all FHS events**):**

Name: _____

Email: _____ Phone: _____ Ext: _____

Program Coordinator _____

Telephone: _____ Ext: _____

Email: _____

Please provide the following information about the design of the program:

Section B: Target Audiences

Provide an estimate of the total number (#) of attendees:

- ☐ GP/ FP: #_____ ☐ Specialists: #_____
- ☐ Other Health Professional, specify: # _____
- ☐ Students / Trainees: # _____
- ☐ Other: # _____ specify: _____

Section C: Needs Assessment

Please check all methods used for determining Subjective (perceived) and Objective (unperceived) educational needs of the target audience **(at least one objective and one subjective educational need should be used):**

Objective (unperceived)
- ☐ Self-Assessment Tests
- ☐ Peer Performance Review/Audit
- ☐ Direct Observation of Practice Performance
- ☐ Expert Advisory Group
- ☐ Patients Feedback
- ☐ Chart Audits
- ☐ Clinical Incidence Reporting
- ☐ Quality Assurance Data from Hospitals or Regions
- ☐ Provincial Databases
- ☐ Published Literature
- ☐ M&M Rounds

Subjective (perceived)
- ☐ Survey of Target Audience
- ☐ Focus Group
- ☐ Opinion of Planning Committee Members
- ☐ Prior Evaluation of CPD/CME Activity

***Please attach the Needs Assessment document**

Section D: Learning Objectives

Attach a statement describing what knowledge, skills or attitude the participant will acquire by participating in this program (a copy of your program brochure will suffice if it includes this information). Please refer to CHSE Guidebook for information on writing SMART Learning Objectives.

Section E: Program Planning Committee

Provide a list of all members of the Planning Committee including Titles, Professional Designations, Department or Organization Affiliations and Contact Details (a copy of the program brochure will suffice if it includes this information). For MainPro Credits, at least one (1) CFPC Member must be a Member of the Planning Committee and have substantial involvement in development, planning, and implementation of the program.

Section F: Planning Committee Conflict of Interest

Attach completed Conflict of Interest Forms (CHSE forms found on Website) for each of the Planning Committee Members. Please ensure that information is provided on how to mitigate any potential bias or conflict of interest.

Section G: Program Content/Agenda

Attach a copy of the Program Agenda with exact times for each activity including Question & Answer, Panel Discussion, Nutritional Breaks and Meals. Ensure your Agenda includes 25% interactive participant time (a copy of the program brochure will suffice if it includes this information).

Section H: Promotional Material

Provide a copy of all Promotional Material for the event (include list of web based materials if applicable).

Section I: Program Faculty

Provide a list of Speakers including Titles, Professional Designations, Department or Organization Affiliations and Contact Details (email and /or phone numbers).

McMaster University HEALTH SCIENCES

Section J: Learning Methods

Please indicate which presentation method(s) will be used (check all that apply)

- ☐ Lecture
- ☐ Workshops
- ☐ Videotape
- ☐ Panel Discussions
- ☐ Simulation
- ☐ Case Presentation with Patients
- ☐ Case-Based Small Groups
- ☐ Demonstrations of Techniques
- ☐ Practice-Based Small Group
- ☐ Other, please specify: _____

Section K: Evaluation

Please indicate which method(s) will be used to evaluate the program:

- ☐ Audience Feedback
- ☐ Pre-Post Knowledge Testing
- ☐ Practice Reflection Exercise
- ☐ Other, please specify: _____

***Please attach a copy of the program evaluation form**

Section L: Sponsorships / Budget

Please identify all sources and amounts of sponsorship revenue supporting this event:

Sponsor Name	Dollar Amount
	$
	$
	$

***Please attach a copy of your preliminary budget and any additional pages as required**

Section M: Registration Fee

Please list Registration Fee Amount(s):

- ☐ NO CHARGE, specify: _____
- ☐ Physician $_____
- ☐ Students / Trainees $ _____
- ☐ Other Health Professionals $ _____

Section N: Declaration of the Planning Committee Chair/Course Director

As the Planning Committee Chair/Course Director, I accept the responsibility for the accuracy of the information provided in this application. I accept the responsibility that any potential bias or conflict of interest is stated in this application, shared with the event attendees and mitigated effectively.

I have read the "McMaster University, Continuing Health Sciences Education Policy on Support of Continuing Education Events from commercial sources, in accordance with the CMA policy", and to the best of my knowledge, I certify that this event complies with these guidelines.

I will ensure that all the teaching content in this CME/CPD activity has scientific validity, integrity and objectivity and is evidence based.

At the completion of the event I agree to provide the Continuing Health Sciences Education Program with an electronic copy of the speakers/ presenters and attendees list with full names, addresses, and professional titles or designation. **I will also provide a copy of the participants' evaluation of the event and a detailed final budget.** This information will be mailed to the CHSE Program NO later than four weeks after completion of the event.

As we collect information from speakers and participants, I am committed to full compliance with the Freedom of Information and Protection of Privacy Act (FIPPA).

Signature of the Planning Committee Chair/Course Director

X_____

Section O: Declaration of the McMaster University Faculty of Health Science Representative on the Planning Committee

As the McMaster University FHS Representative on the Planning Committee for this CME/CPD event, I hold an active academic appointment at McMaster University and I have been actively involved in the planning of this event.

If the Chair of this Planning Committee is not a McMaster Faculty Member, I will ensure that all the responsibilities stated above under **Section N** and those stated in the CHSE Event Planning Guide Book are complied with.

Signature of McMaster University FHS Representative on the Planning Committee

X_____

Section P: Academic Chair/Assistant or Associate Dean/Director or Designate Approval and Support

As the Academic Chair/Assistant or Associate Dean/Director or Disignate of the Department of

_____

I approve and support this event as a McMaster University FHS event. My program/faculty has had substantial input into the planning, organization, development, and implementation.

Signature of Academic Chair of the Department/ Assistant or Associate Dean/ Director or Designate

X_____

Please mail/fax the completed form and supporting documents to:

Attention: Program Manager
McMaster University, Faculty of Health Sciences, CHSE Program
1280 Main Street West, MDCL, Room 3510
Hamilton, ON L8S 4K1 Canada
FAX: 905.572.7099

Note: Include all Supporting Documents, otherwise the review WILL NOT occur.

Supporting Document Checklist:

- ☐ Needs Assessment
- ☐ Learning Objectives
- ☐ Planning Committee
- ☐ Planning Committee Conflict of Interest
- ☐ Content/Agenda
- ☐ Promotional Material
- ☐ Faculty Listing
- ☐ Evaluation Form
- ☐ Sponsorships/Budget
- ☐ Signatures from all parties, Section N-P

McMaster University HEALTH SCIENCES