McMaster University HEALTH SCIENCES

CHSE

www.fhs.mcmaster.ca/conted

CONTINUING HEALTH SCIENCES EDUCATION PROGRAM

APPLICATION FOR PROGRAM ACCREDITATION

Submit completed Application and supporting documents by email, fax, in person or by mail to:

Attention: Program Manager
THE CHSE PROGRAM, McMaster University, Faculty of Health Sciences
1280 Main Street West, MDCL, Room 3510, Hamilton, ON, L8S 4K1, Canada • E: silla@mcmaster.ca • F: 905.572.7099

APPLICATION REVIEW FEE SCHEDULE*

Application **WILL NOT** be reviewed until payment has been received. Additional fees may apply for complex reviews.

CHSE Activity	McMaster Activity	External (Non-McMaster) Activity Developed by a physician Organization with involvement of FHS faculty members
Group Learning Activity (MOC Section 1 and/or Mainpro 1)	$400	$1,200
Simulation, Self Assessment, MOC Section 3 and Online Modules	$1,000	$2,500

APPLICATION FOR ACCREDITATION CHECKLIST:

Please submit this checklist along with your Application for Accreditation and all supporting documentation in the following order:

- ☐ 1. Accreditation Fee Payment Enclosed*
- ☐ 2. Application for Accreditation Checklist
- ☐ 3. Completed Application with all required Signatures, signed by McMaster Representation:
  - ☐ Planning Committee Chair or ☐ McMaster Faculty Member on the Planning Committee
  - ☐ Academic Chair of the Department / Assistant or Associate Dean / Director or Designate
- ☐ 4. Written Needs Assessment
- ☐ 5. List of Planning Committee Members
- ☐ 6. Learning Objectives
- ☐ 7. Program Content / Topics / Agenda
- ☐ 8. Faculty and Speakers list
- ☐ 9. Completed Declaration of Conflict of Interest forms for all Planning Committee Members
- ☐ 10. Budget (Revenues / Expenses, including CHSE Accreditation Review Fee and Attendee Fees)
- ☐ 11. Promotional Materials (if Applicable)
- ☐ 12. Evaluation and Feedback form:
  - ☐ Objectives Stated at the top of the Evaluation and Feedback Form
  - ☐ Question on Bias with Comment Section (Commercial and other Forms of Bias)

PAYMENT INFORMATION:

PROGRAM NAME: _____

Payment by: VISA ☐ M/C ☐ AMEX ☐ CASH ☐ CHEQUE ☐ (Pls make cheque payable to **"McMaster University"**) JOURNAL ENTRY ☐ (Pls complete the Journal Entry to The CHSE: 45 808000 10187 75119)

Amount to charge: $ _____ . 0 0

Credit Card Holder's Name: _____

Card number: _____

Expiry: Month ☐☐ Year ☐☐ CVC ☐☐☐ Signature _____

NOTE: Please include all Supporting Documents, otherwise the review **WILL NOT** occur.

- - Please refer to **THE GUIDEBOOK** for clarification on completing any of the steps in this application - -

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

Phone: 905-525-9140 x22671
Fax: 905-572-7099
Email: cmereg@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.

STEP 1

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: _____

Is this program being co-sponsored with a Non FHS partner? ☐ Yes ☐ No | If yes, specify: _____

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.**

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: _____

STEP 2

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

☐ GP/ FP: #_____ ☐ Specialists: #_____

☐ Other Health Professional, specify: # _____

☐ Students / Trainees: # _____

☐ Other: # _____ specify: _____

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

***Attach the Needs Assessment document**

STEP 3

Planning Committee Members:
Attach 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.

STEP 4

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.

Program Content and Topics (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).

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 ☐ Practice-Based Small Group ☐ Demonstrations of Techniques

☐ Other, please specify: _____

Program Faculty and Speakers:
Attach a list of Program Faculty and Speakers including Titles, Professional Designations, Department or Organization Affiliations and Contact Details (email and /or phone numbers). Select faculty who can present content that meets the learning objectives.

STEP 5

Managing Conflict of Interest:
Attach completed Declaration of Conflict of Interest Form (CHSE forms found on Website) for each of the Planning Committee Members, Faculty and Speakers. Please ensure that information is provided on how to mitigate any potential bias or conflict of interest.

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STEP 6

Budget:
Attach a copy of your preliminary budget. *(For a sample budget, please refer to Appendix I in the CHSE Guidebook)*

Registration Fees:
Provide Registration Fee Amount(s):

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

External Funding (Sponsorships):
Please identify all sources and amounts of sponsorship revenue supporting this event:

Sponsor Name	Dollar Amount

STEP 7

Evaluation Tools:
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**

STEP 8

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

DECLARATIONS AND APPROVALS

A. 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 have read the CHSE Guidebook for Planning, Developing and Delivering Continuing Health Sciences Education Activities and all related policies. To the best of my knowledge this program is developed in compliance with the CHSE Guidebook and is adherent to all related policies. I accept all the responsibilities of the Chair of the planning committee as outlined in the CHSE Guidebook.

Signature of the Planning Committee Chair/Course Director

X_____ Date: _____

B. 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 **Declaration A** and those stated in the CHSE GuideBook are complied with.

Signature of McMaster University FHS Representative on the Planning Committee

X_____ Date: _____

C. Academic Chair/Assistant or Associate Dean/Director or Designate Approval and Support:
As the Academic Chair/Assistant or Associate Dean/Director or Designate 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_____ Date: _____

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INTAKE REVIEW

ACADEMIC REVIEW

FOR MCMASTER UNIVERSITY CHSE USE ONLY

Program Name: _____

Date Received: YEAR ____ MONTH __ DAY __

Event Date: YEAR ____ MONTH __ DAY __

Date 1st Review: YEAR ____ MONTH __ DAY __

Reviewed by: _____

Documentation Checklist:

- ☐ 1. Accreditation Fee Payment Enclosed
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For RCPSC MOC:

Is the event developed by a Physician Organization? ☐ Yes ☐ No Name: _____

Does the Planning Committee have a RCPSC Fellow? ☐ Yes ☐ No Name: _____

For CFPC MainPro:

Does the Planning Committee have a CFPC Member? ☐ Yes ☐ No Name: _____

McMaster FHS Event?

- ☐ Yes - Academic Chair, Associate/Assistant Dean or Program Director signature on application or email confirming FHS event status
- ☐ No - External Event

Academic Review completed by: _____ (Assistant Dean/CHSE Representative)

REVIEW RESULTS	DATE	DETAILS	
☐ Approved	20__ __ / __ __ / __ __		
☐ Rejected	20__ __ / __ __ / __ __		
REVIEW REQUESTS	**DATE**	**DETAILS**	**DATE RECEIVED**
☐ Requested More Information	20__ __ / __ __ / __ __		20__ __ / __ __ / __ __
☐ Requested Change to Application	20__ __ / __ __ / __ __		20__ __ / __ __ / __ __

Communication attached? ☐ Yes ☐ No ☐ N/A

Signature: X_____

YEAR ____ MONTH __ DAY __

Date 2nd Review (if applicable):

YEAR ____ MONTH __ DAY __

Approval:

Date Final approved:

Signature: X_____

Invoice:

Application Fee: $_____

Attendance Certificate Fee: $_____ / _____ per participant

Tithe Applicable: ☐ Yes ☐ No

Approved for number (#) of credits:

- ☐ MainPro M1: _____
- ☐ MOC Section 1: _____
- ☐ MOC Section 3 (Simulation): _____
- ☐ MOC Section 3 (Self Assessment): _____
- ☐ N/A: _____

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