**Grant Application Intake Form**

If a pharmaceutical company requires the ACCME Provider (not the requesting institution or department) to submit online grant applications, please complete and submit this form to the CME Coordinator assigned to your program. The Office of CME (OCME) will submit the online grant application on behalf of the sponsoring department, affiliate, or joint-sponsor. **Please note the administrative fees listed below for this service.**

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| **Educational Grant Application Fees** | |
| **Direct/ Single Provider Activity** | **Joint Provider Activity** |
| Online Grant Submission $100 per grant | Online Grant Submission $250 per grant |
| Online Status Reports $50 per report | Online Status Reports $100 per report |
| Online Reconciliation $100 per grant | Online Reconciliation $250 per grant |

**It is the responsibility of the sponsoring department, affiliate, or joint-sponsor to become familiar with each company’s online grant application process PRIOR to submitting this form.**

Once you have completed this form, submit it via email to your assigned CME coordinator. Additionally, please attach the following documentation. Each item below should be submitted as a separate Word or PDF document and should be clearly titled.

* + Letter of Request (LOR), on letterhead, specific to each company listed below
  + Needs assessment
  + Learning objectives
  + Program description
  + Implementation plan (if needed by Grantor)
  + Contingency Plan(if needed by Grantor)
  + Plan for Outcomes Measurements (typically the evaluation)
  + PDF of brochure (if available)
  + W9 (Of institution the check should be written)

**General Activity Information**

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| --- | --- |
| **Activity Title:** |  |

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| **Activity Date(s):** |  |

|  |  |
| --- | --- |
| **Venue (include full name and address):** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Company Name:** | **Web Link to Online Application:** | **Amount of Grant Request:** | **Additional Information:** |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |

**Therapeutic Areas – List ALL applicable areas:** (Ex: Oncology, Cardiology, Rheumatology, etc.)

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**Disease State- List ALL applicable Disease states:** (Ex: Acute Ischemia Stroke, Breast Cancer, Gastrointestinal Cancers, General Oncology, Hepatitis B/C, Rheumatoid Arthritis, etc.)

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**Complete this Section for Each Type of Delivery Format**

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| **Breakdown of audience (identify each specialty separately including fellows and/or nurses)** | | | | |
| **Audience Group (physician, nurses, PA, etc.):** | **Specialty** | **# of Invitations to be sent** | **# of Expected Learners** | **# of Learners to Receive Credit** |
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| **DELIVERY FORMAT #2:** | **Venue (if same as above type “Same”):** | **Date / Release and Expiration Date:** |
| Live conference / symposium |  |  |
| Live Internet Activity |  |  |
| Enduring Material  🞎 Web-based Activity  🞎 Journal  🞎 Audio / CD-ROM  🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **N/A** |  |

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| **Breakdown of audience (identify each specialty separately including fellows and/or nurses)** | | | | |
| **Audience Group (physician, nurses, PA, etc.):** | **Specialty** | **# of Invitations to be sent** | **# of Expected Learners** | **# of Learners to Receive Credit** |
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**Additional Activity Information**

**Additional Information: limit to 200 characters each**

1. **Criteria Used to Select the Faculty**

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1. **Audience Generation (marketing) Plan**

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1. **Activity Implementation Plan and Timeline**

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1. **How Will You Assess and Document Outcomes**

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**Level of outcomes will be achieved? (this should match what was chosen on your approved CME application)**

* + - * Level 1 – Participation 🞎 Level 2 – Satisfaction
      * Level 3 – Learning 🞎 Level 4 – Competence
      * Level 5 – Performance 🞎 Level 6 – Patient Health
      * Level 7 – Community Health

Will this program use a pre- test or pre-evaluation? 🞎 Yes 🞎 No

Will this program use a post-test or post-evaluation? 🞎 Yes 🞎 No

Will this program use a standard scale (i.e. Likert scale) to measure program effectiveness? 🞎 Yes 🞎 No

Are there additional CE credits offered (such as nursing CEs, AOA. ACOG, AAFP, etc.): 🞎 Yes 🞎 No

If yes, name of accredited institution:

Number of Credits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Educational Grant Funds Should be Remitted to:** | |
| Check made out to: |  |
| To the Attention of: |  |
| Mailing Address: |  |
| Address 2: |  |
| City, State, Zip Code |  |

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| --- | --- |
| **Third Party / Joint Sponsor Information (IF APPLICABLE)** | |
| Name |  |
| Contact Person: |  |
| Mailing Address |  |
| City, State, Zip Code |  |
| Email Address |  |
| Phone Number |  |
| Fax Number |  |
| Tax ID (attach W9) |  |
| Authorized Signature for LOA |  |
| Email Address |  |

**Grant submissions should be edited, formatted and proofed prior to their submission to the Office of CME. The Office of CME will submit information as provided to them.**

Thank you, you will receive an invoice from your CME coordinator after requested applications have been submitted.