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.** These fees will be applied to your post-activity invoice.

|  |  |  |
| --- | --- | --- |
| **OCME Grant Fees** | | |
| **OCME Service** | **Directly Provided Activity** | **Jointly Provided Activity** |
| OCME Grant Submission | $125 per grant | $250 per grant |
| Online Status Report | $50 per report | $100 per report |
| OCME Grant Reconciliation | $125 per grant | $250 per grant |
| OCME Grant Review (not submitting) | $25 per grant | $50 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
  + Agenda
  + Brochure (if available)
  + W9 (of institution the check should be written)

|  |  |  |  |
| --- | --- | --- | --- |
| **Request Details** | | | |
| **Company Name** | **Web Link to Online Application** | **Amount Requested** | **Additional Information** |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **General Activity Information** | | | |
| **Activity title** |  | **Activity date(s)** |  |
| **Venue name and address** |  | | |
| **List all applicable therapeutic areas**  *E.g. Oncology, Cardiology, etc.* | 1.  2.  3. | | |
| **List all applicable disease states**  *E.g. Acute Ischemia Stroke, Breast Cancer, etc.* | 1.  2.  3. | | |
| **Program description** |  | | |
| **Learning objectives** |  | | |
| **Implementation plan**  *How the activity will be planned and executed, timeline, etc.* |  | | |
| **Contingency plan**  *Action plan in the event of cancellation or other major changes* |  | | |
| **Plan for outcomes measurements**  *Typically, this is the post-activity evaluation.* |  | | |
| **Criteria used to select the faculty** |  | | |
| **Method for creating the budget** |  | | |
| **Audience generation plan**  *How activity will be marketed (e.g. email campaign, social media posts, etc.)* |  | | |
| **Audience reach** *I.e. local, regional, national, international* |  | | |
| **Deadline for grant response** |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Target Audience** | | | | |
| **Audience group**  *List separately (e.g. physicians, nurses, PAs, etc.)* | **Specialty**  *(e.g. oncology, cardiology)* | **Total invitations to be sent** | **Total learners expected** | **Total learners to receive credit** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Outcomes**  **Select the highest level that applies** | | | |
| **Select** | **Level** | **Description** | **Sources of Data** |
|  | 4 | Competence  *The degree to which participants show in an educational setting how to do what the educational activity intended them to be able to do*  *Note: The post-activity evaluation meets this level.* | Objective: Observation in educational  setting  Subjective: Self-report competence, intent to change |
|  | 5 | Performance  *The degree to which participants do what the educational activity  intended them to be able to do in their practice* | Objective: Observed performance in  clinical setting  Subjective:  Self‐report of performance |
|  | 6 | Patient Health  *The degree to which the health status of patients improves due to  changes in  practice behavior of participants* | Objective:  Health status measures  recorded in patient charts  Subjective:  Patient self-report of health status |
|  | 7 | Community Health  *The degree to which the health status of a community of patients  changes due to changes in the practice behavior of participants* | Objective: Epidemiological data and  reports  Subjective:  Community self‐report |

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

Will this program use a post-test or post-evaluation? 🞎 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Information**

Requesting department is responsible for coordinating grant payments. The OCME will not collect or coordinate payments on the department’s behalf.

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

Electronic/ACH Payments

Please provide banking information and/or wire instructions if you plan on accepting electronic payments.

|  |  |
| --- | --- |
| **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 |  |