McMaster University, Continuing Health Sciences Education Program (CHSE)

Attention: ANGELA SILLA, CHSE Acting Program Manager
P: 905-525-9140 x26327 | F: 905-572-7099 | E: cmeapps@mcmaster.ca | W: www.fhs.mcmaster.ca/conted

MAILING ADDRESS:
McMaster University, Continuing Health Sciences Education
1280 Main Street West, DBHSC, Room 5009, Hamilton, ON L8S 4K1

DELIVERY ADDRESS:
McMaster University, Continuing Health Sciences Education
100 Main Street West, 5th Floor, Room 5009, Hamilton, ON L8P 1H6

APPLICATION FOR PROGRAM ACCREDITATION/CERTIFICATION

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 8 weeks prior to your activity.**

APPLICATION REVIEW FEE SCHEDULE*

Application **WILL NOT** be reviewed until payment has been received. Payment does not guarantee Accreditation/Certification and is non-refundable.
Additional fees apply for complex reviews or expedited applications.

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+) (if received 8 weeks prior)	$400		$1,200	
Simulation, Self Assessment, MOC Section 3 & Online Modules	$1,000		$2,500	
Review without Accreditation/Certification	**To be determined depending on the complexity of the application**			
Expedited Applications	6 weeks prior additional 25%	4 weeks prior additional 50%	2 weeks prior additional 75%	If less than 2 weeks prior, requires approval from CHSE Manager

APPLICATION FOR ACCREDITATION/CERTIFICATION CHECKLIST:

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

- ☐ 1. Accreditation/Certification Fee Payment enclosed*
- ☐ 2. Application for Accreditation/Certification 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 ☐ Perceived ☐ Unperceived
- ☐ 5. List of Planning Committee Members (Professional Designations required)
- ☐ 6. Learning Objectives
- ☐ 7. Program Content / Topics / Agenda ☐ CanMEDS-FM/CanMEDS Roles
- ☐ 8. Copy of Speaker Invitation Letter
- ☐ 9. 25% Interactivity
- ☐ 10. Faculty and Speakers list (Professional Designations required)
- ☐ 11. Completed Declaration of Conflict of Interest forms for **all** Planning Committee Members
- ☐ 12. Budget (Revenues/Expenses, including CHSE Accreditation/Certification Review Fee, Attendee Fees & 3% Research & Innovation Tithe *if applicable)
- ☐ 13. Promotional Materials (if applicable)
- ☐ 14. 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)
  - ☐ Indicate which CanMEDS-FM/CanMEDS Roles were addressed

PAYMENT INFORMATION: **ACTIVITY NAME:** ______________________________

Payment by: VISA ☐ M/C ☐ AMEX ☐ CASH ☐ CHEQUE ☐ (Pls make cheque payable to **"McMaster University"**) JOURNAL ENTRY ☐ Pls provide your Journal Entry Chart Field String below: ______________________

Amount to charge: $ ____ . 0 0

Credit Card Holder's Name: ______________________________

Card number: ______________________________

Expiry: ____ Year ____ CVC ____ Signature ______________________________

NOTE: Include all supporting documents, otherwise the review **WILL NOT** occur.

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

McMaster University Health Sciences

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STEP 1

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

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

Is this activity being co-developed? ☐ Yes ☐ No | If yes, specify: ____________________

- If no, specify Physician organization: ____________________

Activity Name: ____________________

Activity Date(s) and Time(s): ____________________

Activity 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 Mainpro+ (choose one of the following):
  - ☐ Group Learning (live conference, rounds, journal clubs)
  - ☐ Self Learning (online with live interaction)
- ☐ 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)
- ☐ Review without Accreditation/Certification. According to FHS Policy on governing the use of the McMaster logo.

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

Type of Activity:

☐ Conference ☐ Rounds ☐ Simulation ☐ Journal Club ☐ PBSG

☐ Online ☐ 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 activities**):**

Name: ____________________

Email: ____________________ Phone: ____________________ Ext: __________

Activity 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 perceived and unperceived educational needs of the target audience & ensure they have been considered in the development of the educational activity **(at least one perceived and one unperceived educational need must be provided):**

Unperceived

☐ Self-Assessment Tests
☐ Direct Observation
☐ Chart Audits
☐ Clinical Incidence Reporting
☐ Guidelines
☐ Published Literature
☐ Expert Advisory Group

Perceived

☐ Survey of Target Audience
☐ Focus Group
☐ Opinion of Planning Committee Members
☐ Prior Evaluation of CPD/CME Activity

For Mainpro+ certification, were CanMEDS-FM/CanMEDS Roles considered in the needs assessment? ☐ YES ☐ NO

If yes, please identify which roles: ________________________

STEP 3

Planning Committee Members:

Attach a list of all Planning Committee members 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 activity (a copy of your activity brochure will suffice if it includes this information). Please refer to CHSE Guidebook for information on writing SMART Learning Objectives.

Please check which CanMEDS/CanMEDS-FM role(s) will be addressed during this learning activity:

☐ Medical Expert ☐ Communicator ☐ Health Advocate ☐ Professional
☐ Collaborator ☐ Manager/Leader ☐ Scholar

***All checked items must include the supporting needs assessment evidence**

Activity 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 activity 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 ☐ Panel Discussions ☐ Case Presentation with Patients
☐ Case-Based Small Groups ☐ Practice-Based Small Group ☐ Demonstrations of Techniques ☐ Audience Response Device
☐ Video Conference ☐ Webcast ☐ Webinar ☐ Simulation
☐ 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.

Speaker Communication:

Attach an example of a speaker invitation letter that must include the following:

- Overall learning objectives and individual topic objectives (including CanMEDS-FM/CanMEDS Roles)
- Instruction to incorporate evidence (especially Canadian data)
- Instruction to address barriers to change

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.

STEP 6

Budget:
Attach a copy of your preliminary budget & ensure to include the **Accreditation/Certification Review Fee, Certificate Fee ($15/$25), 3% Research & Innovation Tithe (if applicable)** *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 activity:

Sponsor Name	Dollar Amount

STEP 7

Evaluation Tools: Please indicate which method(s) will be used to evaluate the activity:

☐ Audience Feedback
☐ Pre-Post Knowledge Testing

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

☐ Practice Reflection Exercise
☐ Audience Response Device
☐ Other, please specify: ______________________

STEP 8

Marketing/Promotional Material:
Provide a copy of all Marketing/Promotional Material for the activity (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 activity 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 activity, I hold an active academic appointment at McMaster University and I have been actively involved in the planning of this activity.

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 activity as a McMaster University FHS activity. 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: ______________________

INTAKE REVIEW

FOR MCMASTER UNIVERSITY CHSE USE ONLY

Activity Name: ____________________

	YEAR	MONTH	DAY		YEAR	MONTH	DAY
Date Received:				Activity Date:			
Date 1st Review:				Reviewed by: ____________________			

Documentation Checklist:

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For RCPSC MOC:

Is the activity developed by a Physician Organization? ☐ Yes ☐ No Name: ____________________

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

For CFPC MainPro+: ☐ Group Learning ☐ Self Learning

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

McMaster FHS Activity?

☐ Yes - Academic Chair, Associate/Assistant Dean or Program Director signature on application or email confirming FHS activity status

☐ No - External Activity

Invoice:

Application Fee: $____________________

Attendance Certificate Fee: $__________ / __________ per participant

Tithe Applicable: ☐ Yes ☐ No

McMaster University HEALTH SCIENCES

ACADEMIC REVIEW

Academic Review completed by: ____________________ (Assistant Dean/CHSE Coordinator)

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____________________

Date 2nd Review (if applicable): YEAR [ ] MONTH [ ] DAY [ ]

Approval: YEAR [ ] MONTH [ ] DAY [ ]

Date Final approved: ____________________

Signature: X____________________

Approved for number (#) of credits:

- ☐ MainPro+: ☐ Group ☐ Self Learning __________
- ☐ MOC Section 1: __________
- ☐ MOC Section 3 (Simulation): __________
- ☐ MOC Section 3 (Self Assessment): __________
- ☐ Review without Accreditation/Certification. According to FHS Policy on governing the use of the McMaster logo.