



Please note: The purpose of this form is to give the CME office and Director of Medical Education information on your activity planning process for individual sessions of an approved Recurrent Seminary Series (RSS). This form must be completed for each individual session of an RSS particularly if the RSS sessions happen infrequently. Collateral documents will be needed including: Evaluation forms, outcome measures forms/ process, CME Claim Form, among others.

The key to successful CME activity is to contact the Nicklaus Children's Hospital CME office early and develop a working relationship with the CME representative.

Today's Date: _____

Title of Approved RSS Activity (i.e. the Main Course): _____

Title of Individual Session/ Activity Planned _____

Date of Activity: _____ Lead Department/Division: _____

Location of planned session: _____

Session Chair/Lead: _____ # of CME Credit Hours: _____

Who is the Target Audience? (Check all that apply)

- Primary Care Physicians Subspecialty Physicians
 Other Healthcare Professionals (Please Specify): _____

What is the Targeted Area? i.e. Marketing Reach – Please Specify (Check all that apply):

- Nicklaus Children's Hospital Local (i.e. County) State (Florida)
 Regional (i.e. Southeast) National International

Will You seek additional professional credits (i.e. nursing CEUs) for this session?

- No Yes If Yes, Please specify: _____

What educational needs of the target audience will this session address?

What knowledge gaps of the target audience will this session address? (e.g. new guidelines,...)

Learning Objectives for this Session: Please provide up to three learning objectives for this session.

At the conclusion of this session, participants should be able to:

1. _____

2. _____

3. _____

How will do you plan to evaluate the desired educational outcomes? (How will you know and measure that the audience learned what you intended for them to learn?)

- Standard Evaluation Audience Response Pre/Post-tests Patient Outcomes
 Other – Please Specify: _____

Do you expect to receive any financial support from outside Nicklaus Children's Hospital (Commercial support, exhibitors, grants, etc..)?

- No Yes If Yes, Please specify: _____

Are any other organizations sponsoring or helping to promote and/or hold the activity?

- No Yes If Yes, Please specify: _____

Please list any physicians serving on the planning and/ or delivery of the content of this session.

- | | | |
|-------------------|----------------------------------|----------------------------------|
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
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| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |

Are any other health professionals (non-physicians) serving on the planning and/ or delivery of the content of this session? (e.g. Nurses, social workers, ARNP, PAs, Techs, RTs...)

- No Yes If Yes, Please specify: (Check all that applies)
- | | | |
|-------------------|----------------------------------|----------------------------------|
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
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| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |

Are any Patients/ Parents serving on the planning and/ or delivery of the content of this session?

- No Yes If Yes, Please specify: (Check all that applies)
- | | | |
|-------------------|----------------------------------|----------------------------------|
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |

Are any other physicians-in-training (Medical Students, Residents, Fellows) serving on the planning and/ or delivery of the content of this session? (e.g. Nurses, social workers, ARNP, PAs, Techs, RTs...)

- No Yes If Yes, Please specify: (Check all that applies)
- | | | |
|-------------------|----------------------------------|----------------------------------|
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |
| Who? (Role) _____ | <input type="checkbox"/> Planner | <input type="checkbox"/> Speaker |

Estimated total # of attendees: _____

Estimated total # of Physicians attendees: _____

Estimated total # of non-NCH attendees: _____

Estimated total # of nursing attendees: _____

Checklist:

Please make sure to include the following documents listed in the checklist below along with this form:

- Completed and signed Planning Form**
- Sample agenda for the session with titles of talks and speakers**
- List of speakers along with their contact info/ email addresses**
- Sample "Save the Date" or any marketing material (if designed) for approval**
- Completed disclosure form by session lead, and all planners and coordinators (if not already completed)**
- Any additional materials e.g. sample evaluations, assessment tools, questions, surveys....**

The CME Department will work with you on securing the following items:

- 1- *Registration process (Link will be provided to be embedded by marketing into the webpage or the flyer)*
- 2- *CME Claim Form*
- 3- *Sign-in Sheets*
- 4- *Session Evaluations (with input from the session planning group)*

Signature of Session Chair: _____

Signature of Department or Division Chief and/or Administrator: _____

Title: _____

Please return the completed form to the Department of Medical Education at Nicklaus Children's Hospital by Fax: (305)-669-6531 or by E-Mail: cme@Nicklaushealth.org

FOR CME OFFICE USE ONLY

Date received:

Approved as Submitted **Approved with Modifications** **Declined**

Comments: _____

