



**Please note:** The purpose of this form is to give the CME office and Chair general information on your activity. A completed application form and collateral material will be due in the CME office **4 months** prior to the date of the proposed CME activity. Once this request is approved, a timeline and checklist will be given to you to direct you through the process

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 Activity: \_\_\_\_\_

Activity Date: \_\_\_\_\_

Department/Division: \_\_\_\_\_

Physician Planner: \_\_\_\_\_

Program Contact: \_\_\_\_\_

Contact E-Mail: \_\_\_\_\_

Contact Phone#: \_\_\_\_\_

**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 activity?**

- No  Yes If Yes, Please specify: \_\_\_\_\_

**What educational needs of the target audience will this activity address?**

**How will desired educational outcomes be evaluated?**

- 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: \_\_\_\_\_

Estimated total # of attendees: \_\_\_\_\_

Estimated total # of Physicians attendees: \_\_\_\_\_

Estimated total # of non-NCH attendees: \_\_\_\_\_

Estimated total # of nursing attendees: \_\_\_\_\_

Will you charge registration fee for this activity?       No       Yes

**Assistance requested of the CME office (Check all that apply):**

- |  |  |  |                                     |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Credit Provision Only   | <input type="checkbox"/> Grant Applications*                                 | <input type="checkbox"/> Registration* | <input type="checkbox"/> Marketing* |
| <input type="checkbox"/> On-site support*        | <input type="checkbox"/> Meeting Management* (Contracts, catering, AV, etc.) |  |                                     |
| <input type="checkbox"/> Exhibitor solicitation* | <input type="checkbox"/> Other (Please specify) _____                        |  |                                     |

*\* Please note: The above requested assistance (with the exception of Credit Provision) may not be offered by the CME office or may be offered for an additional fee. In some instances, the office of CME might be able to assist you by providing you with available resources to meet those needs*

**Signature of Activity 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](mailto:cme@Nicklaushealth.org)

**FOR CME OFFICE USE ONLY**

**Date received:**

- Approved as Submitted     Approved with Modifications     Declined

**Comments:** \_\_\_\_\_