NICKLAUS CHILDREN'S HOSPITAL

CME ACTIVITY REQUEST FORM

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)*:

☐ Credit Provision Only ☐ Grant Applications* ☐ Registration* ☐ Marketing*
☐ On-site support* ☐ Meeting Management* (Contracts, catering, AV, etc.)
☐ Exhibitor solicitation* ☐ 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

FOR CME OFFICE USE ONLY

Date received:
☐ **Approved as Submitted** ☐ **Approved with Modifications** ☐ **Declined**

Comments: _____