

APPLICATION FOR PROGRAM ACCREDITATION

You can either print, complete by hand and fax this form, or fill it out online, print and fax it.
To complete this PDF form online you will need the free Adobe Acrobat Reader or the full Adobe Acrobat product.
Return this document to the CHSE Office **at least one month prior** to your program.

Please fax the form and supporting materials to the attention of the:
Program Administrator Continuing Health Sciences Education 905.572.7099

A \$300 non-refundable processing fee will be charged for application review.

***Upon approval an additional fee will be charged per registrant for maintaining the registrant data base.**

Date of Application: _____

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

Is this program being co-developed by: _____

This program is being co-sponsored with another Non FHS partner:

Yes No If yes, specify: _____

Program Name _____

Program date(s) and time(s) _____

Program location (institution/resort/hotel/city, province or state) _____

Indicate the credit categories required for the target audience (check all that apply):

- The College of Family Physicians of Canada MainPro M1
- The Royal College of Physicians and Surgeons of Canada MainCert
- American Medical Association - AMA PRA Category 1

*Note: Planning committee membership must include an active member of the colleges for respective categories requested.

Section A: Please provide the following information about the program:

Type of the Program:

- Conference
- Journal Club
- Workshop
- PBSG
- Seminar Series
- E-learning module
- Rounds
- Other, please specify: _____

Planning Committee Chair * _____

Institution / organization _____

Discipline _____

ADDRESS:

Street/City: _____

Province/State _____ Postal Code/ZIP _____

Telephone _____ Fax _____

Email: _____

***Must hold an active appointment with the Faculty of Health Sciences, McMaster University.**

Discipline/Academic Chair: Name: _____

Email: _____

Program Coordinator (if different from above) _____

Address: _____

Street/City: _____

Province/State _____ Postal Code/ZIP _____

Telephone _____ Fax _____

Email: _____

Section B: Please provide the following information about the design of the program:

Target audiences: Please provide an estimate of the total number # of attendees:

- GP / FP: _____
- Specialists: _____
- Other Health Professionals, specify: _____
- Students / Trainees: _____

Section C: Needs Assessment

Please check all methods used for determining perceived and unperceived educational needs of the target audience:

- | | |
|---|--|
| <input type="checkbox"/> Survey of target audience | <input type="checkbox"/> Patient care audit |
| <input type="checkbox"/> Quality assurance review | <input type="checkbox"/> Peer performance review / audit |
| <input type="checkbox"/> Consensus of experts | <input type="checkbox"/> Faculty perceptions |
| <input type="checkbox"/> Prior conference evaluations | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Self-assessments | |

*Please attach the target audience needs assessment document

Section D: Learning Objectives

Please attach a statement describing what the participant will learn from attending this program (a copy of your program brochure will suffice if it includes this information)

Section E: Program Planning Committee

Please provide a list of all members of the planning committee including titles, professional designations, department or organization affiliations and contact details (a copy of the program brochure will suffice if it includes this information)

Section F: Program Content

Please attach a copy of the program with exact times for each activity including nutritional breaks and meals (a copy of the program brochure will suffice if it includes this information)

F1: Promotional Material

Please provide a copy of all promotional material for the event that identifies an association with McMaster University Faculty of Health Sciences. (Include list of web based materials if applicable)

Section G: Program Faculty

Please provide a list of speakers including titles, professional designations, department or organization affiliations and contact details.

Section H: Learning Methods

Please indicate which presentation method(s) will be used (check all that apply)

- Lecture
- Case presentation with patients
- Case-based small groups
- Demonstrations of techniques
- Workshops
- Videotape
- Panel discussions
- Practice based small group
- Other, please specify: _____

Section I: Evaluation

Please indicate which method(s) will be used to evaluate the program:

- Pre/post tests
- Audience reaction forms
- Other, please specify: _____

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

Section J: Sponsorships

Please identify all sources and amounts of sponsorship revenue supporting this event:

Sponsor	Dollar Amount

*Please attach additional pages as required

Section K: Registration Fee

Please list Registration fee amount(s):

NO CHARGE or

Physician

\$ _____

Other Health Professionals

\$ _____

Students / Trainees

\$ _____

Section L: Declaration of the Planning Committee Chair

As Chair of the Planning Committee for McMaster University Faculty of Health Sciences, I accept the responsibility for the accuracy of the information provided in this application. I accept the responsibility of ensuring that the information provided avoids potential bias or perception of bias, from any commercial organization supporters. I have read the "McMaster University, Continuing Health Sciences Education Policy on Support of Continuing Education events from commercial sources, in accordance with the CMA policy", and to the best of my knowledge, certify that this event complies with these guidelines.

At the completion of the event I agree to provide the Continuing Health Sciences Education Program with an electronic copy of the speakers/presenters and attendees list with full names, addresses, and professional titles or designation. This list, along with a summary of the evaluations will be mailed to the CHSE Program no later than four weeks after completion of the event. This registration and attendance information will be retained by the CHSE Program for audit purposes in compliance with the Freedom of Information and Protection of Privacy Act (FIPPA).

Signature of Chair of Planning Committee

X _____

Please mail the completed form and supporting documents to:

Program Administrator
Continuing Health Sciences Education McMaster University,
MDCL, 3510
Margaret and Charles Juravinski Education Research and
Development Centre
12*0 Main St. W., Hamilton ON L8E 8=#

or FAX it to us at: 905.572.7099

to the attention of the Program Administrator CHSE
with the supporting documents.



