

**By submitting this completed education plan to the ACOFP, the applying organization agrees to abide by the [ACOFP's Joint Providership Guidelines](#).**

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### Activity Information

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

Estimated hours of instruction: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Activity Type: [click for a drop down list](#)

Are you a non profit? \_\_\_\_\_

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### Primary Contact

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Name: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Applying Organization: \_\_\_\_\_

Mailing/Billing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

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### Outside Organizations

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Are you collaborating with other organizations to plan/conduct this activity? ☐ No ☐ Yes

Name:

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### Activity Summary

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What problem or knowledge issues is to be addressed?

How did you determine this activity is needed?

What do you want the outcome of the activity to be?

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**Learning Objectives** *(List 3 or more objectives that address the identified need)*

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At the end of this activity, the attendee should be able to:

- 1.
- 2.
- 3.

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**Basics**

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Description of activity:

Target Audience:

Activity Date(s): [Click here to enter a date.](#) **to** [Click here to enter a date.](#)

Why is this format appropriate for this activity?:

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**Commercial Support**

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Will this activity receive commercial support? ☐ No ☐ Yes ☐ Applying

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**Promotional Materials**

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Which of the following promotional materials are planned for this activity(Check all that apply)?

☐ Digital Materials (i.e electronic PDF)

☐ Email

☐ Social Media

☐ Printer Material (i.e. postcard)

☐ Website

☐ Other:

**Note:** It is mandatory that the ACOFP logo and CME requirements be placed on all promotional materials. This includes websites, save, the dates, and other collateral pieces.

**\*All promotional pieces must be reviewed and approved by the ACOFP prior to final production and distribution.**

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## Faculty

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- ☐ Include a list of all Program Planning Committee Members

Are members of interprofessional teams involved in the planning of this activity?

☐ No ☐ Yes

Are patient/public representatives involved in the planning of this activity?

☐ No ☐ Yes

- ☐ Include a list of all Faculty/Speakers/Authors

Are members of interprofessional teams involved in the presenting of this activity?

☐ No ☐ Yes

Are patient/public representatives involved in the presenting of this activity?

☐ No ☐ Yes

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## Needs Assessment & Practice Gaps

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Which educational format(s) will be used?

*(check all that apply)*

☐ Panel discussion

☐ Lecture

☐ Small group discussion

☐ Question & answer

☐ Hands-on workshop

☐ Live Polling

☐ Case based discussion

☐ Simulation

☐ Skills based training

☐ Round table discussion

☐ Role playing

☐ Other \_\_\_\_\_

The objectives of this activity are designed

to change: *(check all that apply)*

☐ Competence

☐ Performance

☐ Patient Outcomes

☐ Patients and Their Communities

Which of the following methods were used to determine the **need** for this activity (Check all that apply)?

☐ Survey of Potential Learners/ Evaluations from Previous CME Activities

☐ Survey of Experts in the Topic(s)

☐ New methods of diagnosis/treatment

☐ Medical Literature Review

☐ New Technology

☐ Legislative/Regulatory Changes

☐ Clinical Practice Guidelines

☐ Quality Improvement (QI) Data

☐ New Data/Research

☐ Re-credential/certification requirement

☐ Other:

Which of the following **core competencies** will be addressed by this activity (Check all that apply)?

☐ Patient Care

☐ Practice-based Learning & Improvement

☐ Professionalism

☐ Patient-centered care

☐ Employ evidence based practice

☐ Informatics Utilization

☐ Roles/Responsibilities

☐ Interprofessional Communication

☐ Medical Knowledge

☐ Interpersonal & Communication Skills

☐ Systems-based Practice

☐ Interdisciplinary Team Work

☐ Apply quality improvement

☐ Value/Ethics for Interprofessional Practice

☐ Teams and Teamwork

☐ Other:

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**Evaluation** *(If needed, we are able to provide you with a sample evaluation)*

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What type of evaluation method are you planning on using for the activity (Check all that apply)?

☐ Quiz simulation

☐ Pre- and/or Post-tests

☐ Case Discussion

☐ Other:

☐ Audience Response System

☐ \* Evaluation questions and an evaluation summary will be required as part of your summary report

Which of the following changes will be evaluated as a result of this specific activity (Check all that apply)?

☐ Competence

☐ Performance

☐ Patient Outcomes

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**Required Attachments** *(Omissions may delay application approval)*

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☐ Planner/Faculty disclosure(s)

☐ Planner/Faculty disclosure checklist

☐ Draft promotional materials (if available)

☐ Preliminary agenda with times

☐ Evaluation questions

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**For Enduring Activities Only**

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Launch Date: [Click here to enter a date.](#) Expiration Date: [Click here to enter a date.](#)

*(No more than 3 years from launch date)*

How will learners access the course?

How will learner completion be verified?

\* As part of your summary report we'll be asking for:

- Provide screen shots, the source videos, or PDFs of the activity
- Provide a screenshot of the CME product

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**Signature** *(electronic or handwritten signatures accepted)*

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Organization:

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Print Name:

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Title:

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Signature:

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Date:

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