Post-Activity Report for a CME Activity (One-Time Activity)

Office of Continuing Medical Education - School of Medicine - University of Missouri

This report form is to be submitted to the Office of Continuing Medical Education after the occurrence of a CME activity that had been approved for *AMA PRA Category 1 Credit(s)*™. Report should be submitted within two months after the activity is held. The purpose of the report is to document that the activity was developed and managed in a manner consistent with the guidelines of the Accreditation Council on Continuing Medical Education (ACCME).

I. Title of Activity: _____

Beginning Date: ___/___/_____ Ending Date: ___/___/_____

Type of Activity: ____ Lecture ____ Panel Discussion ____ Simulation
____ Skills/Case based discussion ____ Small group discussion
____ Other: _____

II. Date of this report: _____

III. School of Medicine unit sponsoring this activity: _____

IV. Faculty person who is directly responsible for managing the activity:

Name _____ Title_____

Planning Committee members if different than original application:

Contact Person who is submitting this report:

Name: _____

Email: _____ Phone: _____

V. Documenting Activity – Items to Submit with this Report:

1. Attendance Records (sign in sheets) for physicians who attended the program. This record must include the participant's signature, name (printed), and complete mailing address (including zip code).

2. Publicity materials (please check one):

   ____ Publicity copies included ____ Publicity previously submitted

3. If the activity is Jointly Sponsored, indicate if the actual management of the program differed from that described in the application and please explain the differences:

4. Planning member and Speaker disclosure forms and CV or biographical information for non-MU faculty planners and speakers.

5. Activity Evaluation:

   Designed to Change Competence: ____ Yes ____ No

   Changes in Competence Evaluated: ____ Yes ____ No
   (If yes, please provide written evaluation summary)

Designed to Change Performance? ____ Yes ____ No

Changes in Performance Evaluated? ____ Yes ____ No
(If yes, please provide written evaluation summary)

Designed to Change Patient Outcomes? ____ Yes ____ No

Changes in Patient Outcomes evaluated? ____ Yes ____ No
(If yes, please indicate how outcomes data is collected and provide data).

6. Was there commercial support? ____Yes ____No (If yes, provide the following)

   a. Names of commercial supporters and amounts:

   b. A copy of the written disclosure of support you provided to participants

   b. A copy of the signed letter of agreement with each supporting company.

   c. Documentation that the funds were handled through School of Medicine accounts, and records showing how the funds have been spent to date.

   6.1 Were there exhibitors/vendors? ____ Yes ____ No

7. Attach a copy of any handouts given to participants (check one):

   _____ Handout copies included _____ Handout copies previously submitted

VII. **Approval (signatures required):**

I have reviewed this report and the attached information and believe it to be correct and complete.

_____

Faculty Member Responsible for Managing the Activity Date

_____

Contact Person Date