

# CME Interest Form

**Instructions:** You can type your responses directly into this document or print and write your answers and scan to [EEH-ACME@EEHealth.org](mailto:EEH-ACME@EEHealth.org) to discuss your activity with the CME Department. Please answer all the questions as completely as possible to help us better understand what you want to accomplish and how we can best help you.

1. What is the clinical problem(s) or medical/knowledge issue(s) you wish to address with this activity?

2. How was this determined to be a clinical problem or medical/knowledge issue that needs addressed?

2a. Do you have data to support the clinical problem(s) or medical/knowledge issue(s)

Yes          No          If not currently, can you obtain data?          Yes          No

3. When or where does the problem(s) or issue(s) arise within the practice, hospital or patient care areas?

4. Who are the individuals impacted by the issue(s) or problem(s)/Target Audience? *(Check all that apply)*

Physicians                      Allied Health Professionals                      Other *(Please specify)*  
Patients                              Hospital/Health System

5. What should providers take away from this activity/what should outcomes be and applied in practice?

6. How do you plan to track any potential changes to practice?

7. How would you like to structure this activity?

Live Conference                      Podcast  
Video/Enduring                      Journal CME  
Simulation/Skills-based                      Regular Scheduled Series

*If there is another type of activity structure other than what is listed, please describe the type above.*

# CME Interest Form

Page Two



8. Do you have a presenter(s) planned for this activity? *(List name(s), credentials and specialty)*

<b>Presenter Name(s)</b>	<b>Presenter(s) Credentials</b>	<b>Presenter(s) Specialty</b>
--------------------------	---------------------------------	-------------------------------

9. Do you have a designated planner(s) for this activity? *(List name(s), credentials and department)*

<b>Presenter Name(s)</b>	<b>Presenter(s) Credentials</b>	<b>Presenter(s) Specialty</b>
--------------------------	---------------------------------	-------------------------------

10. Date(s)/Time(s) you would like to hold the activity:

11. Do you anticipate any barriers to learning?

*(e.g. time constraints, process guidelines, budget, consensus, personal/professional bias, etc.)*

12. Which of the generally accepted physician core competencies will be addressed by this activity?

*(Check all that apply)*

- |                              |                            |                                  |
|------------------------------|----------------------------|----------------------------------|
| Practice-based learning      | Interdisciplinary Teamwork | Inter-professional Communication |
| Patient Care                 | Quality Improvement        | Medical Knowledge                |
| System-based QI              | Value/Ethics               | Evidence-based Practice          |
| Roles/Responsibilities Other | Professionalism            | Informatics Utilization          |

(Specify):

Signature:

Printed/Typed Name: