

# Continuing NURSING EdUCATION

# ACCREDITATION REQUEST FORM

# Continuing NURSING EdUCATION

#### **Ingram School of Nursing, Faculty of Medicine, McGill University**

Dear Applicant,

Please answer all questions, if a question does not apply to your activity insert N/A.

**Please sign, date and submit all supporting documentation. An invoice for the application processing fee of $150 will be sent to you from McGill University – Accounts Receivable Department.**

Following approval of your application, an invoice outlining additional fees will be sent to you. If the organizing committee accepts the accreditation offer, a **maximum** charge of $350 plus $5 per certificate will be invoiced. If your request is for an online course, please email the [cne.nursing@mcgill.ca](mailto:cne.nursing@mcgill.ca) for specific instructions.

Please note that the CNE office only accredits Nursing Professional Educational Activities. For Interprofessional Educational Activities please consult web site at: [cpd.mcgill.ca/php/documents.php](http://cpd.mcgill.ca/php/documents.php)

In order to facilitate the accreditation process, all documents are available to you on our web site at: www.mcgill.ca/nursing/continuing-education.

**ACTIVITY INFORMATION:**

|  |  |  |
| --- | --- | --- |
| Educational Activity Title (please note, this exact wording will appear on the certificate of attendance – write the title in the language you want the certificates in) |  | |
| Start / End Date(s): | (yyyy/mmm/dd) | (yyyy/mmm/dd) |
| Start / End Time(s): | (start 00:00) | (end 00:00) |
| Location: |  | |
| Number of Registrants: | Min. # \_\_\_\_\_\_\_\_ Max. # \_\_\_\_\_\_\_\_ | |
| Registration Fee: |  | |
| Total Number of Requested Accredited Hours: |  | |
| Activity URL / Web Site (if applicable): |  | |
| Date Accreditation Request Form Submitted: | (yyyy/mmm/dd) | |
| For CNE Office use Only:  Receipt of Request: | (yyyy/mmm/dd) | |

## ORGANIZING COMMITTEE CHAIR (s) :

|  |  |
| --- | --- |
| Name: | Name: |
| University/Hospital Affiliation: | University/Hospital Affiliation: |
| Telephone: | Telephone: |
| Fax: | Fax: |
| E-mail: | E-mail: |
| Complete Mailing Address: | Complete Mailing Address: |

## 

## CONTACT PERSON FOR INQUIRIES / ADMINISTRATIVE INFORMATION (same as above 🞏)

|  |  |
| --- | --- |
| Name: |  |
| Organization: |  |
| Telephone: |  |
| Fax: |  |
| E-mail: |  |
| Complete Mailing Address: |  |

## FOR INVOICING PURPOSES, COMPLETE THE FOLLOWING INFORMATION REGARDING INSTITUTION/ PERSON THAT WILL BE PAYING THE ACCREDITATION REVIEW PROCESSING FEES:

|  |  |
| --- | --- |
| Institution/Organization: |  |
| Contact Person: |  |
| Telephone: |  |
| Fax: |  |
| E-mail: |  |
| Complete Mailing Address: |  |

## ADDITIONAL ORGANIZING PLANNING COMMITTEE MEMBERS:

|  |  |  |  |
| --- | --- | --- | --- |
| **Member’s Name** | **Area of Practice** | **University / Hospital Affiliation** | **Contact Information** |
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## WHO IS YOUR TARGET AUDIENCE?

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| --- | --- | --- |
| Place a ☑ in the appropriate box: | | |
| Nurses  **🞏** | Nurse Practitioners **🞏** | Other Health Professionals **🞏** |

Describe the identified target audience(s) for this activity. Indicate area of expertise.

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## TYPE OF ACTIVITY:

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| --- | --- | --- | --- | --- | --- | --- |
| Place a ☑ in the appropriate box: | | | | | | |
| Small Group Session/Workshop | | **🞏** | Seminar/Seminar Series | | **🞏** |
| Conference / Course | **🞏** | | Lecture/  Lecture Series | **🞏** | |
| Nursing Ground Rounds/Series | **🞏** | | Other (specify): | | | | |

## 

## HOW WILL THE ACTIVITY BE DELIVERED TO THE PARTICIPANTS?

|  |  |  |
| --- | --- | --- |
| Place a ☑ in the appropriate box: | | |
| In Person  **🞏** | Online **🞏** | Other 🞏 Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## BRIEF DESCRIPTION OF ACTIVITY / PROGRAM:

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| --- |
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## 

Will this activity be repeated within the next twelve (12) months? : **🞏 Yes 🞏 No**

## LEARNING NEEDS IDENTIFICATION:

A needs assessment was done: **🞏 Yes 🞏 No**

If yes, you must submit a summary of the information collected.

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| --- |
| **Learning needs were identified by the following methods:** |
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## GOALS and LEARNING OBJECTIVES

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| --- |
| **Goals/Learning Objectives:** |
| **What knowledge will participants gain?** |
| **Expected impact on professional practice?** |

### 

### **INTERACTIVITY:**

An important component of effective learning is the opportunity to interact with the presenters and learn from the experiences of colleagues. While an interactive approach is preferred, it may not be appropriate to all activities.

|  |  |  |  |
| --- | --- | --- | --- |
| **What learning methods have been incorporated to promote interactive learning?: ☑ all that apply:** | | | |
| Question periods (25% of total time) | **🞏** | Case discussions | **🞏** |
| Seminars/Workshops | **🞏** | Problem-based learning | **🞏** |
| Meet the professor/Expert sessions | **🞏** | Small group discussions | **🞏** |
| Debates, roundtables with audience participation | **🞏** | Journal club format | **🞏** |
| Use of touch-pad audience response systems | **🞏** | Teleconference / Videoconference | **🞏** |
| Interactive poster sessions with discussion | **🞏** | Use of simulators | **🞏** |
| Self-assessment programs or quizzes with feedback | **🞏** | Computer based learning activities with interaction | **🞏** |
| Other (describe): | | | |

**EVALUATION OF LEARNING OBJECTIVES/REFLFECTION:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Will the participants be asked to demonstrate that they have met the learning objectives? (Formal Evaluation)  Yes □ No □  If yes, describe the methods that will be used.   |  | | --- | |  | |  | |  |   2. Will there be opportunities for participants to identify and/or reflect on what they have learned? (One example of this would be a question asking what the participants learned or how they plan to integrate this new knowledge into their practice).  Yes □ No □  If yes, describe the method/s utilized by participants to identify what they have learned.   |  | | --- | |  | |  | |  | |

### **DESCRIPTION OF LEARNING ENVIRONMENT:**

|  |
| --- |
| Please provide a description of your learning environment and explain how this is conducive to meeting the learning objectives? |
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**EVALUATION OF PRESENTERS:**

|  |
| --- |
| **Describe the process by which the presenters will receive feedback on their performance.** |
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| **How will you use the information collected in your activity evaluations to ensure quality improvement over time if the activity is repeated?** |
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## ETHICAL STANDARDS

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| --- | --- |
| The organizing committee had control over the topics, content and presenters selected for this activity. | **🞏 Yes 🞏 No** |

## How were speakers informed of the learning objectives? What instructions were they given?

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| --- | --- |
| The organizing committee assumes responsibility for ensuring the scientific validity and objectivity of the content of this activity. | **🞏 Yes 🞏 No** |

Describe the process used to ensure the validity and objectivity of the activity’s content.

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**BUDGET**

|  |  |
| --- | --- |
| **Financial Support** | **%** |
| **Participants** |  |
| **Associations/Organizations** |  |
| **Companies** |  |
| **Other (specify)** |  |
| **Total** | **100%** |
| **Expenses** | **%** |
| **Presenters** |  |
| **Materials** |  |
| **Secretarial Support** |  |
| **Accommodations** |  |
| **Travel** |  |
| **Other (specify)** |  |
| **Total** |  |

## ACTIVITY/PROGRAM BROCHURE:

A preliminary activity brochure, including goals and objectives of the activity, schedule, general description of the activities, timing, specific topics that will be presented and name of presenters is enclosed with this completed Accreditation Request Form.

🞏 Yes 🞏 No

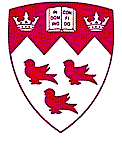
**DECLARATION: ORGANIZING COMMITTEE CHAIR:**

As Chair of the Organizing Committee, I accept the responsibility for the accuracy of the information provided in this CNE Accreditation Request Form. I accept the responsibility of ensuring that the information provided avoids potential bias or perception of bias, from any commercial entity/organization supporters. In addition, I will ensure that all planning committee members and presenters associated with this activity will complete a Declaration of Potential Conflict of Interest Form prior to the start date of the activity.

No later than eight (8) weeks following the completion of the activity, I agree to provide the Ingram School of Nursing Accreditation Office, McGill University, a completed Final Report Form and all supporting materials (as indicated on the CNPE Guidelines) to finalize the accreditation process.

# 

**DATE:** (yyyy/mmm/dd)  **ORGANIZING COMMITTEE CHAIR** (SIGNATURE)



**Commercial Support**

**PRESENTERS / Content selection Disclosure Form**

# Continuing NURSING EdUCATION

#### **Ingram School of Nursing, Faculty of Medicine, McGill University**

**To be completed by the Organizing Committee Chair**

EDUCATIONAL ACTIVITY TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CNE presenters must confer balanced and scientific information. All presenters must discuss advantages, disadvantages and differing points-of-view, and must not promote products and/or services. Furthermore, presenters must disclose in writing, to the activity organizers’, all "off label" content. Additionally, the presenter must disclose to the CNE participants, oral and visual disclosure with slide, any relationships that could affect the event's objectivity or independence.

The Organizing Committee Chair must sign and complete a Declaration of Potential Conflict of Interest Form, the table below and confirm that the activity meets the standards of ethics and independence.

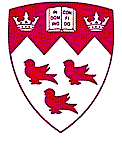
**Sponsor support:**

|  |  |
| --- | --- |
| **Organization or Commercial Entity** | **Amount in dollars (CDN)** |
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**As Chair of the Scientific Planning Committee, I confirm that:**

* the presenters and content for this activity were selected by the Scientific Planning Committee members and were not influenced by any commercial entity.

**DATE:** (yyyy/mmm/dd) **ORGANIZING COMMITTEE CHAIR** (SIGNATURE)



Commercial Competing Interests Form

# Continuing NURSING EdUCATION

#### **Ingram School of Nursing, Faculty of Medicine, McGill University**

EDUCATIONAL ACTIVITY TITLE:

The Educational Activity is:

1. Funded by a single sponsor **🞏**  (Need tocomplete, date and sign form)
2. Funded by multiple sponsor sponsors **🞏**  (Need to **only** dateand sign form)

1. Should a commercial entity’s medication or device appear in the presenters’ slide set, **list all** similar medications or devices in clinical use or in trials from **all** competitors.

List all slides in which the commercial entity’s (sponsor) product(s) or studies related to the sponsor's product(s) are mentioned.

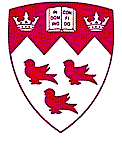
|  |  |
| --- | --- |
| **Sponsor’s Product** | **Slides where the sponsor’s products appear** |
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List all competing product(s) from **all** competitors that are either on the market or are undergoing clinical trials. List the slides where the competing product appears.

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| --- | --- | --- | --- |
| **Sponsor’s Product** | **Competing**  **Product** | **Competing**  **Manufacturer** | **Slides where competing**  **product appears** |
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**DATE:** (yyyy/mmm/dd)  **ORGANIZING COMMITTEE CHAIR** (SIGNATURE)



**DeCLARATION OF POTENTIAL CONFLICT OF INTEREST**

# Continuing NURSING EdUCATION

#### **Ingram School of Nursing, Faculty of Medicine, McGill University**

All Organizing Committee chairs, planning committee members and presenters must complete this form. Declarations must be made to the participants regardless of whether or not a relationship with a commercial entity such as a pharmaceutical organization, medical device company, or a communication firm exists.

**Presenters are asked to declare their Conflict of Interest(s) at the beginning of the presentation (oral and visual disclosure with slide required)**

**EDUCATIONAL ACTIVITY TITLE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**🞏 I do not have an affiliation (financial or otherwise) with a commercial entity.**

* Presenters who are not involved with industry must inform the audience that they have no conflict of interest to disclose.

**🞏 I have/had an affiliation (financial or otherwise) with a commercial entity.**

* Presenters who are involved with industry must inform the audience of the type of affiliation(s), the name(s) of the business corporation(s) and the period covered by their relationship with the commercial entity. Please complete the section below:

|  |  |  |
| --- | --- | --- |
| **TYPE OF AFFILIATION** | **NAME OF CORPORATION** | **DETAILS / DATE (from/to)** |
| I am a member of an advisory board or similar committee for a commercial organization. |  |  |
| I am a member of a speakers’ bureau. |  |  |
| I have received payment from a commercial organization (including gifts, etc...). |  |  |
| I have received a grant(s) or an honorarium(s) from a commercial organization. |  |  |
| I hold a patent for a product referred to in the CNE activity/program or that is marketed by a commercial organization. |  |  |
| I hold investments in a pharmaceutical organization, medical device company, or communication company. |  |  |
| I am currently participating in or have participated in a clinical trial (within the past two years). |  |  |
| Other: |  |  |

|  |
| --- |
| I, , acknowledge that the information above is accurate.  (Please print clearly)  Signature Date  (yyyy/mmm/dd) |

It is the responsibility of the activity organizer to have this Declaration of Potential Conflict of Interest form completed by each resource person: planning committee chair, committee members, presenters, trainers, facilitators, moderators, authors and medical content writers. Also, the organizer will ensure that the information will be made available to the audience by a notation in the course syllabus and an oral and disclosure slide statement will be made by the presenter.

**The following are examples of disclosure statements:**

*I have no conflict of interest to declare; I have no affiliation, honoraria or monetary support from an industry source.*

*or*

*I am a consultant for the XYZ Company; I was recently invited by the XYZ Company; I receive a research grant(s) from the XYZ Company*.

**CNE Accreditation Request Checklist**

# Continuing NURSING EdUCATION

#### **Ingram School of Nursing, Faculty of Medicine, McGill University**

The **completed CNE Accreditation Request Form**, including **all supporting documents**, must be submitted **4 weeks prior to the start date of the activity**.

Signed and completed CNE Accreditation Request Form

Copies of all promotional materials (pamphlets, brochures, websites…)

Copy of the schedule (preliminary if not finalized)

Signed copy of the **Commercial Support, Presenters / Content Selection Disclosure Form** (Page 9 of the

CNE Accreditation Request Form)

Signed copy of the **Commercial Competing Interests Form** (Page 10 of the CNE Accreditation Request Form)

Signed copies of the **Declaration of Potential Conflict of Interest Form** (Page 11 and 12 of the CNE Accreditation Request Form)

Evaluation Form for the Educational Activity

Copies of the PowerPoint Slide Sets

**IMPORTANT:** Late fees will apply if the Accreditation Request Form and/or supporting documents are received less than 4 weeks prior to the start date of the activity.

**Once the accreditation review has been completed, an invoice will be sent with all applicable fees related to the accreditation process for this activity.**

Submit your accreditation request form and supporting documents via email: [cne.nursing@mcgill.ca](mailto:cne.nursing@mcgill.ca)

**For more information:**

CNE Web Site: www.mcgill.ca/nursing/continuing-education