OFFICE OF CONTINUING MEDICAL EDUCATION AND LIFELONG LEARNING

Report on a PI CME / Part IV MOC Activity

Complete and return this form within 30 days after Part IV attestations have been completed.

1. **Activity Information**

   Title: ____ Dates: ___________________________

   Faculty Planner/Project Lead: ___________________________ Administrative Contact: _______________________________________

2. **Individual Disclosure, Resolution of Conflicts of Interest, & Disclosure to Participants**

   Complete the table below. If you have this information already available electronically, then simply include it as an attachment.

   For each individual in control of content, list the name of the individual, the individual's role (e.g., planner, co-planner, faculty, author) in the activity, the name of the ACCME-defined commercial interest with which the individual has a relevant financial relationship (or "None" if the individual has no relevant financial relationships), and the nature of that relationship.

   Note: Please ensure that when you are collecting this information from individuals that you are using the most current definitions of what constitutes a relevant financial relationship and ACCME-defined commercial interest (ie., Planner Disclosure Form, Presenter Disclosure Form).

Name of individual*	Individual's role in activity	Name of commercial interest	Nature of relationship
Example: Jane Smith	Faculty Planner	None	—
Example: Thomas Jones	Faculty	Pharma Co. US	Research Grant

**If there are additional individuals in control of content for the activity, please attach a separate page using the same column headings.*

<u>Attach</u> the following (**required**):

❑ Presenter Disclosure Forms for all individuals listed above who have indicated a conflict of interest, with the "Resolution" section completed in advance of the activity by the Faculty Planner (or other designated individual).

❑ The disclosure information <u>as provided to participants</u> about the relevant financial relationships (or absence of relevant financial relationships) for each individual listed above.

3. **Participant Details**

   <u>Attach</u> the following (required):

   ❑ Participant list of those attending the activity (including those who did not want credit)

   _______ Total number of all participants (including physicians, non-physicians, UM faculty, etc.)

   Of the total number of participants listed above, also provide the following breakdown:

   _____ Total number of physicians (MD's & residents only)

   _____ Total number of UMHS faculty/staff (non-MD's, house officers, PhD's, etc.)

   ❑ *Participant Attestation for Joint PI CME and Part IV MOC Credit* forms for every participant wanting a Certificate of Participation

   ❑ Email addresses for all participants wanting a Certificate of Participation

4. **Commercial Support**

   Note: The ABMS Portfolio Program will not approve any QI activity that receives commercial support, either formal or in-kind.

   ❑ This activity was not commercially supported.

5. **Supporting the UMMS Clinical and Research Mission**

   Does this activity generate trackable referrals to clinical care? ❑ Yes ❑ No

   Does this activity generate trackable referrals to clinical trials? ❑ Yes ❑ No

6. **Financial Summary**

Provide the following revenue sources for the activity (information will be reported to the ACCME):

$ _____________ Commercial support

$ _____________ Advertising and/or Exhibit revenue

$ _____________ Registration fees received, including subscription or publication fees received from CME activity participants

$ _____________ Total governmental monetary grants received from federal, state, or local governmental agencies

$ _____________ Total private monetary donations received from the private sector, including foundations. Note: commercial support is not considered a private donation

Was this activity jointly-provided with a non-UMMS group? ❑ Yes ❑ No

❑ If yes, the detailed financial report is attached here (required).

7. **CME application, credit recording, and/or expedite fees**

You will receive an invoice from OCME&LL detailing the application and/or certificate fees for your activity.

Note: For activities that requested a review with a turn-around of less than 10 business days, an expedite fee of an additional $200 will be charged.

❑ Short code to be used for application, credit recording, and/or expedite fees _____________

❑ Please invoice the following:

Name: ____

Company: ____

Address: ____

City, State, Zip: ____

9. **Departmental Approval**

I have reviewed this report and the attached information and find it to be accurate and complete.	Signature of Faculty Planner Date

Return this form & supporting documentation within 30 days to Ellen Patrick at partivmoc@umich.edu, or mail to:
OCME&LL, 1301 Catherine Street, 5111 Med Sci I, Ann Arbor, MI 48109-5611