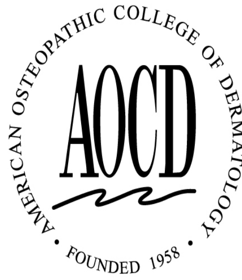

CME Lecture Proposal & Needs Assessment Form

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Telephone: ______________ Email: ______________

Board Certification: AOBD ABD Other ______________

Do you have a current Certificate of Added Qualification? Yes No If so, list area ______________

Lecture Title: (please submit a separate form for each proposal) ______________

____

Proposed Date and Time of Lecture ______________

Lecture Objectives:

1. ______________________________

____

2. ______________________________

____

3. ______________________________

____

CORE Competency Met:

Competency 1: Osteopathic Philosophy, Principles, Practice and Manipulative Medicine

Competency 2: Medical Knowledge

Competency 3: Patient Care

Competency 4: Interpersonal and Communication Skills

Competency 5: Professionalism

Competency 6: Practice-Based Learning and Improvement

Competency 7: System-Based Practice

Brief Description of Lecture Content: ______________

____

____

Why would the AOCD Membership benefit from this lecture?

____

____

____

____

Suggested length: Fifty (50) minutes Ninety (90)minutes Other: ____________________

Suggested format (lecture, panel discussion, case presentation, etc):

____

____

Suggested speakers (Please include speaker contact information):

____

____

____

Please list any speaker conflicts of interest or biases:

____

____

____

Please list at least two evidence based references (i.e. peer reviewed journal, textbook, etc., and provide page numbers, book editions and web links):

____

____

____

Needs Assessments (please list all that apply)

These include:

- New advances in dermatologic treatment
- New methods of diagnosis or treatment
- Availability of new medication(s) or indication(s)
- Development of new technology
- Advances in medical knowledge
- Legislative, regulatory, or organizational changes effecting patient care

____

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____

____

Please provide 3 Pre and Post-Test Questions with answers:

Pre-Test Question 1

____

____

a. ____

b. ____

c. ____

d. ____

Correct Answer: _____

Pre-Test Question 2

____

____

a. ____

b. ____

c. ____

d. ____

Correct Answer: _____

Pre-Test Question 3

____

____

a. ____

b. ____

c. ____

d. ____

Correct Answer: _____

Post-Test Question 1

____

____

a. ____

b. ____

c. ____

d. ____

Correct Answer: _____

Post-Test Question 2

____

____

a. ____

b. ____

c. ____

d. ____

Correct Answer: ____

Post-Test Question 3

____

____

a. ____

b. ____

c. ____

d. ____

Correct Answer: ____

Please return to:

AOCD

P.O. Box 7525

Kirksville, MO 63501

Fax: 660-627-2623 or email to mwise@aocd.org

For CME committee use:	YES	NO
Speaker Verified		
Date and Time Verified		
References verified		
Disclosures verified		
Objectives reviewed		
Core Competencies reviewed		
Needs Assessment reviewed		
CME committee approval		

CME Representative Signature ____ Date __________