MUNSON HEALTHCARE

CME Evaluation for Munson Healthcare CME Activities

ALL PERSONS ATTENDING ANY MUNSON HEALTHCARE CME PROGRAMS MUST COMPLETE THIS FORM.

LAST NAME:
FIRST NAME: MIDDLE INITIAL:
DISCIPLINE:
DATE:
TOPIC:
SPEAKER/FACULTY:

CME ACTIVITY (CHECK ONE):

☐ Anesthesia GR	☐ eClinical Works User	☐ Mammography-Pathology	☐ Orthopaedic GR	☐ Tuesday Grand Rounds	☐ Other_____
☐ Breast Cancer (IBCC)	☐ Emergency Dept. M&M	☐ Maternal Child M&M	☐ Perinatal Quality	☐ Tumor Board	
☐ Cardiac Imaging	☐ Friday Medical Conference	☐ MTOP Conference	☐ Pharmacy & Therapeutics	☐ Trauma PIPS	
☐ Cancer Research	☐ HIPAA Compliance	☐ Neonatal Case Review	☐ Sepsis M&M	☐ Vascular Conference	
☐ CTU Conference	☐ ICU M&M	☐ Neurology EEG GR	☐ Stroke tPA Case Review	☐ VPO	

Indicate change(s) you will make to your practice as a result of the information you received from this CME Activity?

How will you implement these change(s)?

COMMENTS:

THIS CONFIDENTIALITY AGREEMENT MUST BE SIGNED WHEN ATTENDING ANY MUNSON SPONSORED CME ACTIVITY.

When signing below as a participant of a Munson Medical Center (program sponsor) CME Activity, I agree to the following:

It is the legal, moral, and ethical duty of all participants attending education programs to assure each patient's privacy and hold in strict confidence any and all information concerning health status, care and treatment needs, and prognosis discussed. Some information and data presented may also be protected under Michigan statutes for quality improvement and peer review. Because of this: I shall not actively seek to obtain any information regarding a patient's health status beyond which is necessary to effectively perform my job. This includes any type of patient information such as: medical records, billing records, schedules and logs, data available in all computerized systems, quality improvement/peer review documentation, and verbal exchange or discussion. I will not divulge or discuss patient information discussed in this education activity within hearing range of other patients or family members, in any public areas of the hospital, or in community settings. The only such discussions I shall have concerning such matters will be with the physicians, nurses, or clinical staff caring for the patient. I realize that my failure to comply with these requirements may result in suspension of my privilege to attend education programs sponsored by Munson Medical Center, suspension of my privileges, and/or my privilege to call upon Munson Healthcare and could result in a legal action against me and/or my company by the patient and Munson Healthcare.

Actual number of hours attended_ ___ SIGNATURE_ _____

If this form is signed electronically, the electronic signature of the above will indicate compliance and agreement

ACCREDITATION-DESIGNATION STATEMENT: *This activity is approved for AMA credit. The CME office will submit to AOA for review/approval.*

AMA: Munson Medical Center is accredited by the Michigan State Medical Society to provide continuing medical education for physicians.
Munson Medical Center designates this live activity for a maximum of ____ *AMA PRA Category 1Credit(s) ™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AOA: Munson Medical Center is an AOA accredited provider. Munson will submit this CME Activity to the American Osteopathic Association-Division of CME. Designation of credit is pending approval by the AOA-CCME.

Return to Munson Medical Center, CME Office, 1105 Sixth Street, Traverse City, Michigan 49684 within 10 days of program.