**RSS Activity Application for Continuing Medical Education**

**UT Health San Antonio - Office of CME**

7703 Floyd Curl Drive, MSC 7980

San Antonio, Texas 78229

**RSS Conference Coordinator**

Melissa Craig

Email: [CraigM@uthscsa.edu](mailto:CraigM@uthscsa.edu)

Phone: 210.567.6531

* Beginning June 2021 – RSS Activity Applications for CME are valid for two academic years.
* Please submit one copy of this RSS Activity Application for CME **two months in advance of the RSS or at the beginning of planning**. Processing will usually be completed in a shorter timeline, but cannot be guaranteed.
* **Completed RSS Activity Application for CME along with required attachments should be submitted via email to Melissa Craig /** [**CraigM@uthscsa.edu**](mailto:CraigM@uthscsa.edu)**.**
* Payment of CME fees may be made by:
* Interdepartmental transfer
* Credit card (American Express/Discover/ MasterCard/Visa)
* Check made payable to the**Office of CME** and mailed to the address above

1. **Organization Information**

|  |  |
| --- | --- |
| **Name of Dept/Division** |  |
| **RSS Chair** |  |
| Planning Members *(please consider diversity among your planning committee)* |  |
| E-Mail Address |  |
| Telephone Number |  |
| **Finance Director/Business Administrator** |  |
| E-Mail Address |  |
| **RSS Activity Coordinator** |  |
| E-Mail Address |  |
| Telephone Number |  |

1. **Activity Information**

|  |  |
| --- | --- |
| **RSS Activity Title** |  |
| **Beginning Date of RSS Series** (mm/dd/yyyy) |  |
| **End Date of RSS Series** (mm/dd/yyyy) |  |
| **Start Time** |  |
| **End Time** |  |
| **Day of the Week** |  |
| **Frequency** | **\_\_** Daily  **\_\_** Weekly  **\_\_** Monthly  **\_\_** Quarterly  **\_\_** Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Activity Location** |  |
| **Activity Type** | **\_\_** Grand Rounds **\_\_** M&M  **\_\_** Lecture Series **\_\_** Case Conference    **\_\_** Journal-based **\_\_** Tumor Board |
| **Target Audience**  (MD, DO, RN, PharmD, etc) |  |
| **Expected Number of Participants** |  |
| **Educational Format**  (select all that apply) | **\_\_** Lecture **\_\_** Case Based Discussion  **\_\_** Panel  Simulation  Skill Based Training **\_\_** Small Group Discussion  **\_\_** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Brief Description of Course Content**  Please consider when planning your activity:   * topics on diversity, inclusion and equity * diversity among your speakers |  |
| **State the Educational Need** |  |
| **What are the professional practice gaps to be addressed?** |  |
| **What evidence do you have to support these gaps?** | **\_\_** Survey data from stakeholders, target audience members, content experts, etc.  **\_\_** Input from stakeholders such as healthcare professionals, managers, or content experts  **\_\_** Evidence from quality studies and/or performance improvement activities to identify opportunities for improvements  **\_\_** Evaluation data from previous education activities  **\_\_** Trends in literature, law and health care  **\_\_** Direct observation  **\_\_** Other – Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Is it a gap in the healthcare professionals’ knowledge, competence, or performance?**  (select all that apply) | **\_\_** Knowledge  **\_\_** Competence (skills)  **\_\_** Performance |
| **Based on the need/gaps the activity is addressing, what is the activity designed to change?**  (select all that apply) | **\_\_** Competence  **\_\_** Performance  **\_\_** Patient Outcomes |
| **Upon completion of this course, learners will be able to:**  (learning objectives) |  |
| **Maintenance of Certification II** | **Will this activity provide Maintenance of Certification II (MOC II)?**  If so, an additional CME administrative fee will be assessed.  **\_\_**Yes **\_\_** No |
| **Ethics Credit** | **Will this activity include content related to ethics (check one)?**  **\_\_** Yes *(Please provide presentation to Office of CME at least two weeks prior to start of activity for review/approval by a UT Health SA ethicist)*  **\_\_** No |
| **Pain Management and the Prescription of Opioids** | **Will this activity include any of the following topics related to Pain Management and the Prescription of Opioids?**  **• best practices, alternative treatment options, and multi-modal approaches to pain management** that may include physical therapy, psychotherapy, and other treatments;  **• safe and effective pain management related to the prescription of opioids and other controlled substances, including education regarding:**  - standards of care;  - identification of drug-seeking behavior in patients; and  - effectively communicating with patients regarding the prescription of an opioid or other controlled substances; and  **• prescribing and monitoring of controlled substances.**  **\_\_** Yes **\_\_** No |
| **CME administrative fee**  (select # of sessions per year) | **\_\_** **1-12** sessions / $1,000.00 annual fee per year  **\_\_** **13-24** sessions / $1,500.00 annual fee per year  **\_\_** **25-36** sessions / $2,000.00 annual fee per year  **\_\_** **37-52** sessions / $2,500.00 annual fee per year |
| **Documents to attach and email along with the Activity Application** | **Please attach:**   * **Marketing Material (flyer/brochure)** * **Schedule of dates for your activity** |