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| **Notification of Accredited CPD Activity** | | | | | | |
| Activity Title |  | | | | | |
| Location of activity  (Place or web address) | HMC Medical Education Center  HMC Hospital Sites ITQAN Simulation Center  HITC  Other *(Specify)* | | | | | |
| Format of Activity | Face to Face | | Online | | | Blended |
| Mix Activity [Category 1& 3]  Yes  No | **Category 1**  ***Group Learning Activity*** | | | | **Category 3**  ***Assessment Activities*** | |
| Conference  Workshop  Symposia  Seminar  Educational rounds  Journal clubs  Online synchronous & Blended | | | | Knowledge Assessment Program  Simulation  Multisource Feedback  Clinical Audits  Direct Observation of Procedure or Performance in Practice | |
| Propose CPD Hours | Cat 1: \_\_\_\_\_ | | | | Cat 3: \_\_\_\_\_\_ | |
| Activity date (From-To)  (dd/mm/yyyy - dd/mm/yyyy) | Note: Kindly notify 2 weeks in advance for any added offering date or date cancellation | | | | | |
| How many times will this activity take place within the accreditation period? | **☐** 1  **☐** 2 **☐** 3 **☐** 4+ | | | | | |
| Maximum allowed number of attendees per offering | Face to Face: | | Online: | | | Total Number: |
| Average Expected Attendees per Offering | Face to Face: | | Online | | | Total Number |
| Target audience  (Check all that apply) | Allied Health Professionals  Complementary Medicine  Dentists  Nurses  Pharmacists  Physicians  Other (please list): | | | | | |
| Audience Type | HMC Staff only Selected or Invited Audience only Open for All | | | | | |
| Has the CPD activity been sponsored by one or more sponsors? | YES NO | | | | | |
| Type of Funding | None | Financial | | In-kind | | Both Financial & In-kind |
| Is there a registration fee for participants? | YES NO  If YES how much: | | | | | |
| Is the activity Co-provided? | YES NO  If YES, Please Indicate: | | | | | |
| Is the activity Jointly provided? | YES NO  If YES, Please Indicate: | | | | | |
| Contact Name/ Email Add /  Phone Number |  | | | | | |
| Website/link for Registration |  | | | | | |

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| **Attestation** | | |
| **Please read each of the following confirmation statements carefully and check the box as your attestation** | | |
|  | We understand and attest that our activities adhere to the DHP-AS’s (administrative, educational, and ethical standards) definition of CPD. [Category 1 and/or Category 3] | |
|  | We understand and attest that all the materials submitted to the DHP in any format will not contain any untrue statements, will not be misleading, will fairly present the organization, and are the property of the organization applying for accreditation | |
|  | We understand and attest that DHP policies and procedures prohibit the provider from submitting to the DHP-AS, any individually identifiable health information. | |
|  | We understand and attest that our organization will not be eligible for DHP accreditation if we present activities that promote recommendations, treatment or manners of practicing medicine that are:  Known to have risks or dangers that outweigh the benefits or are known to be ineffective in the treatment of patients.  Devoted to advocacy of unscientific modalities of diagnosis or therapy. | |
|  | We have reviewed all disclosed financial relationships of speakers, moderators, facilitators, and/or authors in advance of this CPD activity and have implemented procedures to manage any potential or real conflicts of interest. | |
|  | We understand and attest that our organization must ensure that every repetition of the activity is done in accordance with the program’s description as outlined in the original application materials. | |
| **Name and Signature of the Department Head or**  **CPD Program Lead** | | **Name and Signature of the SPC Chair or**  **Nurse Planner** |
| **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Required Attachments**  **Attachments for Category 1 and/or Category 3 Activity** | | |
| *You must include the following attachments with your application. We recommend that you submit the CPD documents to the CPD Program Lead* ***12* weeks** *prior to the activity start date. Any submission,* **less than 30 days,** *shall not be accepted*.  *We are unable to process applications without all the attachments.* | | |
| **Attachment #** | **Description of Attachment** | **Yes or No** |
| Attachment 1 | **List of Scientific Planning Committee (SPC) and minutes of SPC meetings** (and any other correspondence including emails). |  |
| Attachment 2 | The completed **learning needs assessment** form with evidence(s) to validate the needs. |  |
| Attachment 3 | The **agenda program/brochure with** written activity schedule, learning outcomes or objectives for the overall activity and individual sessions, name of speakers, moderators, facilitators and assessors, DHP-AS accreditation statement and SPC COI review statement. |  |
| Attachment 4 | Any other **materials** used to promote or advertise the activity (if applicable). |  |
| Attachment 5 | The **completed CPD activity conflict of interest form** (Part A-COI Declaration of ever**y SPC member, all speakers, faculty, moderators, facilitators and assessors** with Part B- COI Management form by either the **SPC Chair, Department Chair or CPD Program Lead**).  *You must email the form to overseas speakers and request to complete and sign the Part A- CPD activity COI and scan it back to you.* |  |
| Attachment 6 | The **evaluation form(s)** developed for this activity. |  |
| Attachment 7 | The approved **HMC Financial Management Application** form or the signed **budgetary statement form.** |  |
| Attachment 8 | A copy of the signed **HMC sponsorship contract form** between SPC and sponsor’s ( if applicable) |  |
| Attachment 9 | A copy of the sponsorship **invitation letter and exhibitor prospectus** (if applicable). |  |
| Attachment 10 | The **sponsors’ satellite session/program** (if applicable) without MOPH logo, accreditation statement, accreditation hours, learning objective, activity code and declared as unaccredited activity. |  |
| Attachment 11 | Sample of **actual content presentation** (with topic title, COI disclosure and management, learning objective, content with references) or printout, as appropriate |  |
| Attachment 12 | A copy of the **Peer Review form** on the content(s) of the presentation by the SPC (if applicable) |  |
| Attachment 13 | A copy of the signed **MOU or MOA** or official correspondence between SPC and CPD partner (if applicable) |  |
|  | **You do not need to format a certificate. We will send an approved template when an activity is approved** |  |

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| **Additional attachments for Category 3 Assessment Activities** | | |
| **Attachment #** | **Description of Attachment** | **Yes or No** |
| Attachment 14 | |  | | --- | | Tools, methods or scenario used to enable participants to demonstrate or apply their knowledge, skills, clinical judgment or attitudes in all key areas or domains. | |  |
| Attachment 15 | Tools or methods used to enable participants to record their answers to any assessment questions. |  |
| Attachment 16 | Tools or methods used to give feedback to participants on their performance in assessment activities. |  |
| Attachment 17 | Tools or methods used to guide participant reflection after participating in assessment activities. |  |
| Attachment 18 | Any multisource feedback instruments |  |
| Attachment 19 | Any direct observation assessment instruments |  |

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| **Post CPD Activity Documents** | | |
| **Note: Document 1- 3**  Submit **not later than 10 days after the CPD activity** to the respective CPD Program Department | | **Yes or No** |
| Document 1 | **CPD Attendance Sheet (Excel)for DHP report**  (with DHP license number, QID and Total CPD credit hours) |  |
| Document 2 | **CPD Registration/Attendance List**  Mandatory details: record of sign-in/time-in and sign-out/time out, number of actual CPD hours allocated for each participant.  Optional details: country of residence, healthcare professional group, company/employer |  |
| Document 3 | **CPD Activity Evaluation Summary/Survey** |  |
| **Note: Document 4**  Submit **not later than 30 days after the CPD activity** to the respective CPD Program Department | | **Yes or No** |
| Document 4 | **CPD Activity Completion Form** only for paid CPD activity |  |