



## **Joint Providership Preliminary Application**

The American Society for Metabolic and Bariatric Surgery's (ASMBS) Continuing Medical Education (CME) Joint Providership Program is available on a case by case basis. This form **MUST** be submitted to the ASMBS Department of Education

***prior to the start of any planning of the education activity.***

The Pre-Application is **mandatory** in order to be in compliance with the Accreditation Council for Continuing Medical Education (ACCME) Accreditation Criteria. In accordance with ACCME regulations, the American Society for Metabolic and Bariatric Surgery must ensure that everyone who is in a position to control the content of the educational activity has disclosed to us all relevant financial relationships with any commercial interest. Therefore, ALL Planning Committee members (those in the position to affect the content of the activity) must complete a Disclosure form **prior to the planning of the activity.**

Once your preliminary application is approved you will receive an email from the ASMBS Program Department that will contain instructions and the full CME application documents.

The following documents **MUST** be received with the submission of this preliminary application either in the form below or as attachments:

- 1) Information about intention to find commercial support
- 2) Overview of meeting goals or minutes from program planning meeting
- 3) Educational Practice Gaps You Hope to Address (see below)
- 4) Mission of the State Chapter
- 5) CV for Activity Medical Director and Activity Coordinator
- 6) Organization web address (*if applicable*)

**Organization Name:**

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**Meeting Name:**

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**Location & Date(s):**

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**Main Contact Information:**

**Name:**

**Role:**

**Street Address:**

**Phone Number:**

**Email Address:**

Please submit these forms to Danielle Marsh (Danielle@asmbs.org)

If you have any questions, please call 352-331-4900



**1. Commercial Support:**

Will commercial exhibits be a component of this activity?

Yes  No

Will commercial sponsorships be a component of this activity?

Yes  No

Will you be applying for educational grants for this activity?

Yes  No

**2. Meeting Goals**

Please provide us with an overview of your goals for this meeting; this can include minutes from a planning meeting and/or preliminary agenda.

### **3. Practice Gaps Addressed**

What are some identified areas that need improvement in the field of Bariatric Surgery? How will your program address these 'gaps' in knowledge, competence or performance? (Example: A provider identified as a professional practice gap the fact that board members and physicians are not prepared for changes that will result from healthcare reform because executives and management teams have not been proactive in board development to prepare for the changes. To address this, the provider designed a leadership conference to confer strategies for achieving optimal board performance.)

1.

2.

3.

### **4. Mission of Your State Chapter**

### **5. CV of Activity Medical Director and/or CME Coordinator (*Please attach CV*)**

### **6. Organization Web Address (If available)**

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## Joint Providership Activity Agreement:

This agreement is between the American Society for Metabolic and Bariatric Surgery (ASMBS) and **[Organization Name]**, a State Chapter of the ASMBS.

By its authorized signature on this agreement **[Organization Name]** affirms that its CME activity serves to develop/maintain the knowledge competence and/or performance that a physician uses to provide services for patients. Further, the **[Organization Name]** accepts accountability for all aspects in the planning and implementation of these CME activities in compliance with the Accreditation Council for Continuing Medical Education (ACCME) Accreditation Criteria and ACCME Standards for Commercial support.

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ASMBS and **[Organization Name]** agree to the following:

- 1) Planners' disclosures must have been submitted to ASMBS prior to the planning of this activity in order to be in compliance with ACCME regulations.
- 2) All proposed CME activities must be reviewed and approved by the ASMBS CPD Department to ensure compliance with ACCME Accreditation Criteria
- 3) ASMBS, as the ACCME-accredited sponsor, will assign the appropriate *AMA PRA Category 1 Credit*<sup>™</sup>. Further, ASMBS shall have the authority to withdraw the designation of credit and revoke this Agreement at any time during the planning or implementation of the activity if the **[Organization Name]** fails to meet the requirements of the ACCME or the terms of this Agreement.
- 4) **[Organization Name]** shall comply with all deadlines pertaining to the completion and transmission to the ASMBS of all required forms and data pre- and post-activity.
- 5) All commercial support for the activity is subject to approval of the ASMBS.
- 6) All Letters of Agreement (LOA) pertaining to educational grants must be approved and signed by ASMBS prior to the start of the activity.
- 7) All monies from commercial supporters should be paid directly to the [ ].  
[ ] shall provide ASMBS with a copy of the finalized agreement and a post-activity accounting as to how the funds were disbursed. In the event the supporter requires the check be payable to ASMBS, the check will be reissued by the ASMBS to the [ ] minus a 5% administrative fee.
- 8) All promotional materials (brochures, advertisements, flyers, syllabi, and website information) must be approved by ASMBS in writing prior to being printed.
- 9) Accreditation of the proposed CME activity may not be advertised prior the ASMBS approval.
- 10) [ ] agrees to indemnify and hold harmless ASMBS against any claims or expenses arising from the educational activity.

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If you have any questions, please call 352-331-4900

Fee schedule to ASMBS as follows:

- Application fee of \$200 is nonrefundable and must accompany the completed State Chapter CME Agreement and Application.
- A fee of \$200 per assigned maximum credit for the activity is payable 30 days after approval of activity.

**For the ASMBS:**

Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date: \_\_\_\_\_

Title \_\_\_\_\_

**[Organization Name]:**

Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date: \_\_\_\_\_

Title \_\_\_\_\_

Please submit these forms to Danielle Marsh ([Danielle@asmbs.org](mailto:Danielle@asmbs.org))

If you have any questions, please call 352-331-4900