Continuing Medical Education Registration and Evaluation Form

Title of Activity: Department of Medicine Grand Rounds - Approved Duration: July 1, 2015 - June 30, 2016

The Office of Continuing Education, School of Medicine, University of Missouri is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Office of Continuing Education, School of Medicine, University of Missouri designates this live educational activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim the credit commensurate with the extent of their participation in the activity.

Date of Activity: __________________________________________

Topic for CME session: ______________________________________

Telehealth Site: ____________________________________________

*Name of Participant: ________________________________________

*Address: __________________________________________________

________________________________________________________________

E-mail: _____________________________________________________

*Discipline:

☐ MD ☐ Nurse ☐ Physician Assistant ☐ Pharmacy

☐ DO ☐ Nurse Practitioner ☐ OT/PT/Speech Therapist ☐ EMT/Paramedic

☐ Other: ____________________________________________________

*Were the following overall learning objectives met?

Prepare to maintain board certification in Internal Medicine and its various sub-specialties. ........................................... ☐ ☐ ☐ ☐ ☐

Apply clinical information and research to patient care...... ☐ ☐ ☐ ☐ ☐

Develop lifelong learning skills ............................................ ☐ ☐ ☐ ☐ ☐

Please rate the following:

This information is likely to have an impact on my practice. ☐ ☐ ☐ ☐ ☐

Conflict of Interest Disclosure was made prior to start of activity. ☐ ☐ ☐ ☐ ☐

The Telehealth system was effective in viewing this activity. ☐ ☐ ☐ ☐ ☐

*What did you learn in this CME activity that you will apply to your practice of medicine?

________________________________________________________________

*What change(s) will you incorporate into your practice as a result of knowledge acquired at this activity?

________________________________________________________________

Please share any comments or suggestions you may have:

________________________________________________________________

*required for CME credit

Return via fax to: Karla Imhoff - 573-882-5666