



## Appendix 1: Application Form (AAF)

The Agency is pleased to provide you with this application for continuing Medical Education Accreditation. Please study the document carefully. An understanding of the content will enable an appropriate application and subsequent accreditation

1. Applicant (individual or institution) .....  
Address .....  
Telephone (Mobile).....Office.....  
Email(s).....
2. Name of the Continuing Professional Development (CPD) Coordinator  
Telephone (Mobile).....Office.....  
Email(s).....
3. Date of application.....
4. Date of program (day, month, year).....
5. Title of course/topic/event.....
6. For recurrent (weekly, monthly etc) courses/topic/event  
Frequency ..... Duration ..... Location.....  
Day of week ..... Time of Day.....
7. What will be the credit units for this activity..... (refer to the CPD guidelines)
8. Target Audience in terms of health cadres (Check as appropriate)
  - a. General Practitioners
    - i. Medical doctors
    - ii. Dental Surgeons

- b. Specialists (specify) .....
- c. Others (specify).....
- d. Estimated number of the participants.....

**In presenting courses which qualify for continuing professional development (CPD) credit the CPD provider must be responsive to the Essentials of CDP as set forth by the Accreditation Council for Continuing Medical Education.**

9. **Needs Analysis** for all courses is required by the accrediting agency. Describe the needs analysis conducted in choosing to present this course

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10. What are the specific **learning objectives** of the course? Such learning objectives must be measurable (e.g. participant will learn to interpret and perform a complete intra operative examination of the heart).

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11. Educational plan with modes of delivery (such as;).

Please tick appropriately

Modes of delivery	Tick
Modified lectures	
Small group discussion	
Practical sessions	
workshop	
Computer assisted teaching	

Others (specify).....

12. Outcomes measurements

Please indicate how you are going to measure outcomes of your CPD activities and actions to be taken.

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13. Please attach a copy of the program materials indicating the following information.

	Items	Tick
1.	Content/sessions for which accreditation is being requested.	
2.	Learning objectives	
3.	Duration of program/sessions.	
4.	Speakers.	
5.	Funding sources.	
6.	A copy of the evaluation form ,where applicable	

14. Will a fee be charged?

No	
Yes	

If yes, please specify the amount for ranges for each category

Item	Tick
General Practitioners (Medical and Dental)	
Specialists (Medical and Dental)	

Others (specify).....

15. What are the sources of funding?

a. ....

b. ....

c. ....

NB: Please attach budget

16. Commercial standards of the accreditation agency require the following documentation (included in the CME packet)

- **Letter of Agreement:** If an educational grant was given for the CPD activity, a letter of agreement must be on record within the department/organisation. It defines the giver, the amount and the purpose of the educational grant. It should contain the signatures of representatives of the company (that gave the grant), the department that received the grant, and the CPD office.
- **Disclosure.** If an educational grant was given for this CDP activity, all speakers must disclose whether his / her presentation will include the use of commercial products or services, and, whether his / her presentation will include linkage to the commercial company that provided the grant. attach a copy of the programme materials indicating the following information: