**INSTRUCTIONS**

Please attach the program/agenda/flyer for the session if available, as the program will likely include much of the information referred to in the subsequent questions. If detailed information requested in the following questions is specified in the program agenda, please indicate “see program/agenda”.

**This form is a FILLABLE word form. Please input information into the appropriate fields and SAVE the document to your computer. Then, email the completed document to the MDPAC Office at info@mdpac.ca**

**NOTE: Please allow 6 weeks for your application to be processed.**

Please wait for confirmation of MDPAC accreditation before publishing this on your flyer/brochure.

1. **1. Contact person’s information:**

*Note: the contact person is the person who is submitting the information about the educational activity, to whom any questions about the activity should be directed, for purposes of the accreditation review.*

Name: Enter Name

Position: Enter Position

Phone # Enter Telephone and Extension

E-mail address: Enter Email Address

1. **2. Name of Sponsoring Agency:**

Enter Name of Sponsoring Agency

*Note: this is the name of the organization that is sponsoring or organizing the session and requesting accreditation (e.g., OMA, university, other learning institution, professional organization, hospital, clinic etc).*

Was there a Physician Psychotherapist or Psychiatrist on the organizing committee?

☐ Yes ☐ No

1. **3. Overall Title/ Name of the session** (name of the continuing professional development (CPD) session):

Enter Title of Session.

1. **4. Date and time of the CPD session:**
2. Enter Date and Time of Session

*Note: The Time is the actual learning time of the session (excluding meals and breaks). If there is time allocated during the session for meals and breaks, the times for the educational sessions and the times for the meals/breaks must be specified.*

If this will be a series of sessions, please include all of the dates and times of the sessions.

A series of sessions (both Group CE sessions and CCI sessions) may be approved as a group, for a period not longer than 12 months, as long as all of the required information is provided in this form (or as an attachment).

**5. Location of the sessions and type of setting:**

Enter Location of Session and Type of setting.

*Note: location is the actual location (organization & address) where the session will be held.*

*Type of setting is the learning environment for the session (e.g., classroom, office etc).*

1. **6. Topics and Presenters: Name and Qualifications of the Presenter/Leader of the session:**

Enter Name and Qualifications of Presenter/Leader

*NOTE: The topics must be relevant to the practice of medical psychotherapy or Psychiatry.*

For a single Group CE session- please include all of the topics and presenters for each topic (if this information is not specified on the attached program agenda). For example, a one hour session would generally have one topic and presenter/leader. A full-day session would typically have several topics with several speakers.

For a series of Group CE sessions- please include the topic(s) and presenter(s) and dates for each session (if this information is not specified on the attached program agenda).

For a series of supervisory sessions, with the same supervisor/leader for all of the sessions, please include the name of the supervisor/ leader for the series.

1. **7. Please confirm that this program is being ethically offered in accordance with the CMA Guidelines for interaction with industry.**
2. **These Guidelines can be accessed at**  <http://policybase.cma.ca/dbtw-wpd/Policypdf/PD08-01.pdf>

☐ Yes ☐ No

If “no” please explain.

Please explain

1. **8. What are the goals and the learning objectives of the program?**
2. Enter Goals and Learning Objectives of the Program
3. **9. What percentage of the session has been allocated for interaction (i.e., interaction among the participants, interaction between the participants and the speakers, questions of the speakers etc).**
4. **At least 25% is required**
5. Please indicate % allocated for interaction **%**
6. **10. Will the participants be asked to complete a program evaluation, and will this information be used to modify and plan future programs?** ☐Yes ☐ No

If “no” please explain.

Please explain

1. **11.** Will attendance be taken and will a certificate of attendance be provided either at the end of the session or no later than ten business days after the end of the session?
2. **☐**Yes ☐ No

If “no” please explain.

Please explain

1. **12. Type of Credits being sought for the session:**

**CE-Group (continuing education – group session):**

Please specify type of session:

☐ conference; ☐ seminar; ☐ workshop; ☐course;

other teaching session Please specify

**CCI (continuing collegial interaction):**

Please specify type of activity:

☐ group supervision (e.g., Balint group);

☐ interaction in conjunction with a CE-group session (Note: the CE-group component of the session must be a full day, i.e., 6 hours of approved CE-group credits to obtain an additional 1 hour of CCI credits);

other Please specify

1. **13. Additional Information**

Please enter any additional information which would be helpful in the review of this application.