# BROCHURE/WEB GUIDELINES

The information listed below should appear in all publicity for CME activities sponsored by Wake Forest School of Medicine. As noted, certain information is required. Potential participants should be made aware of a CME activity at least 4-6 months prior to the event.

## CREDIT STATEMENTS

- **AMA PRA*** *(REQUIRED)*
  The Wake Forest School of Medicine designates this [learning format, i.e. live activity, enduring material, journal based, PI?] for a maximum of ___ **AMA PRA Category 1 Credit(s)**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- **AMA PRA – Save the Date postcard**
  This activity has been approved for **AMA PRA Category 1 Credit**.

- **AAFP (if appropriate)**
  This live activity, (insert title of activity), has been reviewed and is acceptable for up to ___ Prescribed credits by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
  
  *Or* if credit approval not received prior to brochure printing, use the following statement:
  
  **Determination of credit is pending.**

- **CEU (if appropriate)**
  This activity is acceptable for ___ CEU’s.

- **Nursing (if not getting NCNA credit)**
  This educational activity can be applied towards your continuing competence plan for maintaining your current licensure with the North Carolina Board of Nursing.

## ACCREDITATION STATEMENT *** *(REQUIRED)*

*The Wake Forest School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.*

*OR* (if jointly sponsored)

*This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Wake Forest School of Medicine and <insert name of non-accredited provider>. The Wake Forest School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.*

## SPONSORSHIP STATEMENT** *(must appear on the cover of the brochure)*

*This activity is sponsored by Wake Forest School of Medicine.*

*OR* (if jointly sponsored)

*This activity is jointly sponsored by Wake Forest School of Medicine and <name of non-accredited sponsor>.*
GENERAL INFORMATION
The following information should be included in all brochures.

- Location
- Dates and Times
- Purpose of Meeting/Goal – why is this meeting being held
- Objectives – list 2-3 things the attendees should be better able to do after attending the activity (same as listed on certification request)
- Target Audience and requirements or prerequisites for attending activity
- Schedule/Content/Methods
- Faculty
- Educational grants  (If applicable, “This CME activity is supported in part by an educational grant from <insert name of pharmaceutical company or manufacturer>”)
- Maps and Parking Info or “Directions will be sent with confirmation. If you don’t receive your confirmation within 2 weeks, please call.”
- Emergency phone #s at conference site
- Exhibitors
- Telephone # for more info along with PAL # 1-800-277-7654
- Web page address – www.wakehealth.edu/cme
- E-mail for questions

FEE
List fees and what those fees include such as handouts, meals, etc. (On a space available basis, there is no fee for scientific sessions held on campus for full-time students, residents or faculty. However, those wishing guaranteed space, materials, breaks and lunch must pay direct costs associated with their participation.)

Registration deadline is 10 working days prior to the meeting date.

CANCELLATION/REFUND POLICY
Cancellations received in writing 10 working days prior to the beginning of the course will receive a full refund minus an administrative charge. Wake Forest University Health Sciences is not responsible for any travel or hotel costs incurred.

<table>
<thead>
<tr>
<th>Fee Range</th>
<th>Charge</th>
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<tbody>
<tr>
<td>$0-50</td>
<td>$15</td>
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<tr>
<td>$51-150</td>
<td>$25</td>
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<tr>
<td>$151 or greater</td>
<td>$50</td>
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CONFLICT OF INTEREST POLICY
It is the policy of Wake Forest School of Medicine to require disclosure of any significant financial interest or any other relationship a faculty member or planning committee member or sponsor has with the manufacturer(s) of any commercial products or services discussed in an educational presentation. This information will be shared with all participants at the conference.

OPTIONAL SERVICES
- Hotel information/Reservation Form
- Directions/map
- Social functions
- Breaks/meals information
- Tourist information
- Comments from past participants
WAKE FOREST LOGO REQUIREMENTS
Please include a Wake Forest School of Medicine logo. Contact our office or Creative Communications for a copy. All publications must be approved by Creative Communications.

AHEC LOGO
Please also include the Northwest AHEC logo. Contact our office for a copy.

REGISTRATION FORM
Registration forms should include:
- a registration deadline - 10 working days prior to the activity
- enrollment limit
- payment options
  - on-line: www.nwahec.org/? __ __ (contact our office for activity number)
  - check - make payable to Wake Forest University Health Sciences and mail to Wake Forest School of Medicine, Office of Continuing Medical Education, Medical Center Boulevard, Winston-Salem, NC 27157-1028
  - Charge to credit card  □ Visa  □ MasterCard  □ AmEx

  Card # ____________________________
  Expiration Date ____________________
  Name on card ______________________
  Signature _________________________

If paying by credit card, registrations may be Faxed to 336-713-7702.

- and the following information

  Please print or type
  Name (as you would like on nametag & certificate) _______________________
  Last 4 digits of Social Security #XXX-XX-________________________
  Degree/Credentials ________________________________
  Specialty ____________________________________________
  Institution __________________________________________
  Address ____________________________________________  □ home  □ office

  City, State, Zip ________________________________
  Daytime Phone ________________________________
  Emergency Contact Phone _______________________
  FAX _________________________________________
  E-mail (required for credit) _______________________

Check/Auth # __________  Office Use Only  Amt Paid __________  Date _______