316 Osuna Road NE, Albuquerque, NM 87107 505-828-0237

APPLICANT AGREEMENT TO POLICIES AND CONDITIONS

- New Mexico Medical Society (NMMS) shall have no financial obligation in connection with the organization and its sponsorship of continuing medical education.
- The applicant shall defend and indemnify NMMS against any and all liability for claims asserted against NMMS arising out of or in connection with NMMS's accreditation of this organization.
- The applicant agrees to fully adhere to all policies and standards as described in the "NMMS Essential Areas and Their Elements" as adopted by the NMMS Continuing Medical Education Accreditation Committee beginning in 1998 and regularly thereafter with ongoing associated updated policies.
- Applicant acknowledges that published material on the accredited program and its activities may use NMMS's name only as required in the accreditation statement. All other references to the New Mexico Medical Society by name or logo are prohibited.
- It is understood that accreditation by the New Mexico Medical Society indicates only NMMS's verification that the program is in adequate compliance with the "NMMS Essential Areas and Their Elements" as adopted by the NMMS Continuing Medical Education Accreditation Committee beginning in 1998 and regularly thereafter with ongoing associated updated policies.
- Accreditation of the organization's continuing medical education program does not indicate nor imply NMMS's endorsement of the program in any way.

I have read, understand, and agree to the above New Mexico Medical Society policies and conditions for the accreditation of our continuing medical education program.

Name of CME Program:

Name of Person Completing Self Study:

Signature and Date _____

Name of Physician Responsible for CME:

Signature and Date _____

Name/Title of Administrator with CME Oversight:

Signature and Date _____

CME PROGRAM ORGANIZATIONAL CONTACTS

Name of Organization: _____

Chair of CME Committee

Name: _____

Complete Address: _____

_____

Phone: _____

Fax: _____

E-mail: _____

Primary CME Staff Contact

Name: _____

Complete Address: _____

_____

Phone: _____

Fax: _____

E-mail: _____

CEO or Organization's Administrator Responsible for Oversight of CME

Name: _____

Title: _____

Complete Address: _____

_____

Phone: _____

E-mail: _____

Others Who Should Receive Copies of CME Correspondence (if any)

Name: _____

Title: _____

Complete Address: _____

_____

Phone: _____

E-mail: _____

DEMOGRAPHIC INFORMATION

1. Type of Organization
Please indicate what classification most accurately describes your organization by placing a "√" next to the most appropriate item.

☐ **Hospital** Number of beds: _____ Occupancy rate: _____

Number of active MD/DO staff: _____

Number of Residents: ____ Number medical students: ____

☐ **Multi-facility hospital or health care system*** Number of beds: _____ Occupancy rate: _____

Number of active MD/DO staff: _____
Number of Residents: ____ Number medical students: ____

☐ **Specialty Society** Number of Members: _____

☐ **Physician Group** Number of Members: _____

☐ **Insurance Company/Managed Care Company**

☐ **Consortium/Alliance***

☐ **Education Company**

☐ **Other** (specify) _____

2. *If your accreditation is for a multi-facility hospital or health care system, or a consortium/alliance, attach a list of the facilities and/or organizations that comprise the applicant entity.

3. If your organization, or any member organization of your consortium or system, is affiliated with a medical school, describe the nature of this affiliation. If NOT, check here: ☐