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| *Medical Specialty ID* | Click here to enter medical specialty society ID number. | | | | | |
| *Name* | Click here to enter first and last name. | | | *Date of Birth* | Click here to enter a date. | |
| *Mailing Address* | Click here to enter mailing address. | | | | | |
| *City* | Click here to enter city. | *State* | Click here to enter state. | | *Zip Code* | 00000 |
| *Phone* | 000-000-0000 | *Email* | Click here to enter working email. | | | |
| **Privacy Statement: Participant Completion Information (PCI) is governed by the applicable specialty board’s confidentiality policy. SR-AHEC assures that appropriate data privacy and security safeguards are in place and conform to all relevant regulatory requirements.** | | | | | | |

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| **PART I: VERIFICATION** | | | | | | | | | | | |
| *Activity Title* | | Click here to enter activity title. | | | | | | | | | |
| *Activity Date(s)* | | Click here to enter a date. | | | | | | | | | |
| *PARS Activity ID* | | Click here to enter PARS activity ID. | | | | | | | | | |
| *Total Credits* | | Total number of program credits | | *Designated MOC Points* | | Total number of MOC points | | | | | |
| **DIRECTIONS:**   1. Please ensure that your contact information is correct and completely filled out. This is how you will be awarded Maintenance of Certification (MOC) points. 2. Fill in the sessions that you attend with the corresponding credit hour(s) and check the type of MOC credit(s) you wish to receive in the Credit Summary Table below. 3. Upon the start of the activity, Southern Regional AHEC (SR-AHEC) Continuing Medical Education (CME) will determine which one of three assessment methods (i.e., Quiz, Reflective Statement, or Commitment to Change Survey) participants can utilize to obtain MOC points. You must complete the designated Part II: MOC Self-Assessment in order to claim MOC points. 4. If a pre- and post-test are used, you must score at least 75% accuracy to earn credit. Multiple attempts are allowed. 5. Return this form to on-site SR-AHEC CME staff. You will receive individual feedback at the completion of the program. | | | | | | | | | | | |
| **CREDIT SUMMARY TABLE** | | | | | | | | | | | |
| *Date* | *Presentation Title* | | *Speaker(s)* | | *Credit Hour(s)* | | *ABIM* | *ABP* | *ABS* | *ABPath* | |
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|  | | | | | **TOTAL** | |  |  |  | |  |

**By signing below, I confirm that I have attended the hours of the sessions listed on this page and request MOC credit, not to exceed the established maximum per session. I understand that it is my ethical responsibility to accurately report attendance at these sessions. I attest that my PCI will be collected and shared in the Accreditation Council for Continuing Medical Education (ACCME) Program and Activity Reporting System (PARS).**

*Participant Signature:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This MOC Verification and Self-Assessment Form documents learners’ meaningful engagement in activities that meet requirements of the ACCME MOC Assessment Recognition Program. This activity is directly or jointly provided by SR-AHEC within the ACCME system and registered for MOC points up to the maximum allowable *AMA PRA Category 1 Credit(s) ™* for which the activity is designated. At least one of the three assessment methods below will be identified by program faculty at the beginning of the session.

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| **PART II: SELF-ASSESSMENT** | | | |
| **QUIZ** | | | |
| **INSTRUCTIONS:**  Record answers to the pre- and post-test below. These quizzes will be incorporated into the session presentation. | | | |
| *Pre-Test* | | *Post-Test* | |
| **Question** | **Answer(s)** | **Question** | **Answer(s)** |
| 1. |  | 1. |  |
| 2. |  | 2. |  |
| 3. |  | 3. |  |
| 4. |  | 4. |  |
| 5. |  | 5. |  |
| **REFLECTIVE STATEMENT** | | | |
| **INSTRUCTIONS:**  Write one or more reflective statements linking your educational/clinical needs with the session’s learning objective(s) and content. Faculty and/or planners will review the reflective statements and provide individual feedback. | | | |
| **COMMITMENT TO CHANGE SURVEY** | | | |
| **INSTRUCTIONS:**  Please provide at least one statement based on what you learned today attesting a commitment to change or to maintain an element of practice.  I will evaluate my patients differently by:  I will make the following change in practice:  I will implement the following change in teamwork or transitions:  I will maintain or strengthen the following in my practice:  Other: | | | |