

The Gulf Coast HIMSS Chapters invite you to respond to a Call for Speakers for the 2018 GC3 Conference.

The 2018 Conference will be **November 15-16, 2018** at the **Riverview Marriott in Mobile, AL.**

If you or someone you know would like to present, please submit the attached speaker information by ***June 15, 2018***. Submissions should be emailed to GC3Speakers@gmail.com with subject line “GC3 Speaker”.

The conference planning committee will review and make topic selections by July 15. Speakers will be provided with complimentary registration for the conference, but are responsible for their own travel expenses.

Thank you for your support of the Gulf Coast HIMSS Conference. We appreciate your commitment to presenting relevant and informative information to the members of the Alabama, Louisiana, and Mississippi Chapters of HIMSS. We hope to see you in Mobile!

GC3 Call for Speakers Form

Only complete proposals will be reviewed/accepted. Please ensure that all required forms are included in the submission.

* Speaker Identification form (one for each speaker)
* Speaker Introduction/Bio (100 words or less)(one for each speaker)
* MNF Attachment (one for each speaker) This allows GC3 to have sessions approved for Nursing Continuing Education credits.
* Ochsner Clinic Foundation CME Disclosure Form (one per speaker) This form allows for the program to be approved for Continuing Medical Education credits.
* Headshot for conference program (one for each speaker)

*Vendors and consultants are invited to present where the vendor's level of knowledge provides value to the attendees. We greatly value the knowledge that vendors bring to our conference, and stress that these sessions are in-depth educational sessions, not opportunities for sales presentations. Vendors are encouraged to have a healthcare professional co-present to strengthen their presentation.*

All presentations must be submitted by **October 5, 2018,** to allow for sufficient time for review by the Education Committee. Late presentations, those that do not reflect the approved proposal, or those that include promotional content may be removed from the conference agenda.

GC3 would like to post your presentation on their website and need your preference, please indicate below:

\_\_\_ Yes, I agree that my presentation can be posted on the GC3 website.

\_\_\_ No, I do not agree to have my presentation on the GC3 website.

**Presentation**

Title of Presentation: Click here to enter text.

Topic of Presentation: Click here to enter text.

Presentation format:

* Panel [ ]
* Lecture [ ]
* Other Click here to enter text.

Learning Objectives (needed for continuing education credits):

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.

Intended audience:

Introductory [ ]  Intermediate [ ]  Advanced [ ]

Length of presentation: Click here to enter text.
(Please allow at least 15 minutes at the end of your presentation for questions from the audience.)

Presentation title: Click here to enter text.

Second Speaker’s name: Click here to enter text.

Speaker’s credentials: Click here to enter text.

Employer: Click here to enter text.

Employer’s address:

Street: Click here to enter text.

City: Click here to enter text.

State: Click here to enter text.

Zip code: Click here to enter text.

Phone: Work number: Click here to enter text.

 Cell number: Click here to enter text.

Email: Click here to enter text.

Bio:

Click here to enter text.Presentation title: Click here to enter text.

Third Speaker’s name: Click here to enter text.

Speaker’s credentials: Click here to enter text.

Employer: Click here to enter text.

Employer’s address:

Street: Click here to enter text.

City: Click here to enter text.

State: Click here to enter text.

Zip code: Click here to enter text.

Phone: Work number: Click here to enter text.

 Cell number: Click here to enter text.

Email: Click here to enter text.

Bio:

Click here to enter text.

**CME Disclosure of** **Relevant Financial Relationships**

As a sponsor of continuing medical education (CME) activities accredited by the Accreditation Council for Continuing Medical Education (ACCME) it is the responsibility of the Ochsner Clinic Foundation Department of Continuing Medical Education (OCME) to establish a mechanism to identify and resolve conflicts of interest (COI) with necessary interventions implemented prior to the activity taking place. It is our policy to ensure balance, independence, objectivity and scientific rigor in all sponsored CME activities.

Therefore, any individual who is in a position to control the content, development, management, presentation or evaluation of an educational activity designated for Category 1 credit in accordance with ACCME’s Standards for Commercial Support must disclose all relevant financial relationships with any relevant commercial interest to the OCME. An individual who refuses to disclose relevant financial relationships will be disqualified from a CME role that will give them the opportunity to affect the development, management, presentation or evaluation of the CME activity. Summary details are provided on the reverse side of this form.

|  |  |
| --- | --- |
| **Name:**  |  |
| **Name of Activity:** |  |
| **Date of Activity:** |  |
| **Role: (i.e. activity director, course faculty, planning committee member, speaker, author of CME, other)** |  |

­□ I, my spouse or partner, has no actual or potential conflict of interest in relation to this program or presentation

□ I, my spouse or partner, has a financial interest/arrangement of affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this program and/or presentation. Summary details are provided on the reverse side of this form.

**I agree that I­­­­­­­­­­­­­­ shall not influence the content relevant to products or services of financial relationships. I understand that as a planner, speaker or author, who may present a current financial relationship, that I have an opportunity to affect content relevant to products or services of that commercial interest. My presentation materials will be free of commercial bias before and during the presentation. If necessary, I agree to have my materials go through a peer review, by the CME Activity Director, prior to the CME Activity, should I posses financial interests relative to the activity content.**

|  |  |
| --- | --- |
| **Signature:** | **Date:** |

|  |  |
| --- | --- |
| **Affiliation/Financial Interest** | **Name of Organization(s)**  |
| **Grant/Research Support** |  |
| **Consultant** |  |
| **Speaker’s Bureau** |  |
| **Stock/Shareholder** |  |
| **Other financial or material support:** |  |
| **Summary details of the affiliation/Financial Interest:** |
|  |
|  |

Please contact the CME at OCF office for further directive.

 **CME Disclosure of** **Relevant Financial Relationships**

**Continued**

The ACCME defines “commercial interest” as any proprietary entity producing health care goods or services, with the exemption of non-profit or government organization and non-health care related companies.

The ACCME defines “relevant” financial relationships as financial relationships in any amount occurring within the past 12 months that create a conflict of interest. Financial relationships are those relationships in which the individual benefits by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g. stocks, stock options, or other ownership interest, excluding diversified mutual funds) , or other financial benefit. Financial benefits are usually associated with roles such as employment, management position, independent contract (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership and other activities for which remuneration is received or expected.

ACCME considers relationships of the person involved in the CME activity ***to include financial relationships of a spouse or partner.*** The ACCME considers financial relationships to create actual **conflicts of interest** in CME when individuals have **both** a financial relationship with a commercial interest **and** the opportunity to affect the content of CME about the products or services of that commercial interest.

OCME must identify and resolve all conflicts of interest prior to the education activity being delivered to learners.

Please contact the CME at OCF office for further directive.

Please return form to: cme@ochnser.org or fax to (504) 842-8287

**MISSISSIPPI NURSES FOUNDATION**

**ATTACHMENT 4 A- Conflict of Interest Form**

**FOR PLANNERS AND PRESENTERS**

Title of Educational Activity:       Education Activity Date:

Role in Educational Activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Employer and Position/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Conflict of Interest**

The potential for conflicts of interest exists when an individual has the ability to control or influence the content of an educational activity **and** has a financial relationship with a *commercial interest*,\* the products or services of which are pertinent to the content of the educational activity. Relevant relationships must be disclosed to the learners during the time when the relationship is in effect and for 12 months afterward. **All information disclosed must be shared with the participants/learners prior to the start of the educational activity. *Relevant relationships****,* as defined by ANCC, are relationships with a commercial interest if the products or services of the commercial interest are related to the content of the educational activity.

Is there an actual, potential or perceived conflict of interest for yourself or spouse/partner?

       Yes       No

**If yes, complete the following table for all actual, potential or perceived conflicts of interest\*\***

|  |  |  |
| --- | --- | --- |
| Check all that apply | Category | Description |
|  | Salary |  |
|  | Royalty |  |
|  | Stock |  |
|  | Speakers Bureau |  |
|  | Consultant |  |
|  | Other |  |

\*\* **All conflicts of interest, including potential ones, must be resolved prior to the planning, implementation, or evaluation of the continuing nursing education activity.**

**Statement of Understanding**

Completion of the line below serves as the electronic signature of the individual completing this Biographical/Conflict of Interest Form and attests to the accuracy of the information given above.

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Typed or Electronic Signature: Name and Credentials (Required) Date**