NEW MEXICO MEDICAL SOCIETY

## APPLICANT AGREEMENT TO POLICIES AND CONDITIONS

- 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 *ACCME Criteria* and *Policies* and in the *ACCME Standards for Integrity and Independence in Accredited Continuing Education.*
- 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 ACCME Criteria and Policies and in the ACCME Standards for Integrity and Independence in Accredited Continuing Education and regularly thereafter with ongoing associated updated policies and standards.
- 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 Program: _____

Signature and Date: _____

Name and Title of Administrator with CME Program Oversight: _____

Signature and Date: _____

# CME Program Organizational Contacts

Name of Organization: _____

Address of Organization: _____

_____

**CEO or Organization's Administrator Responsible for Oversight of CME Program:**

CEO/Administrator Name: _____

Phone Number: _____

Email address: _____

Address (if different from Organization): _____

_____

**Chair of CME Committee:**

Name of Chair: _____

Chair Contact Information: Phone Number: _____

Email address: _____

Address: (if different from Organization): _____

_____

**Primary CME Staff:**

Staff Name: _____

Staff Contact Information: Phone Number: _____

Email Address: _____

Address: (if different from Organization): _____

_____

**Others Who Should Receive Copies of CME Correspondence:**

Name: _____

Contact Information: Phone Number: _____

Email Address: _____

Address (if different from Organization): _____

_____

## Demographic Information

**Type of Organization**

Please indicate what classification most accurately describes your organization by placing a check mark (✓ ) next to the most appropriate item and complete the data requested.

**Hospital:**
Number of beds:
Occupancy rate:
Number of active MD/DO staff:
Number of residents:
Number of medical students:

**Multi-facility hospital of health care system**:

Number of beds:
Occupancy rate:
Number of active MD/DO staff:
Number of residents:
Number of medical students

**Physician Group:** Number of members:

**Insurance Company/Managed Care Company**

**Consortium/Alliance****

**Education Company**

**Government Agency**

**Other (please specify):__**

***Note:** 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.

****Note**: 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