MEDICAL & DENTAL COUNCIL

"Guiding the Profession, Protecting the Public"

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)
APPLICATION FOR PROGRAMME ACCREDITATION

Please refer to the guidelines when completing this application form

Database Details

Please fill in this section of the form as you wish it to be displayed on the "Approved Activities Database." This is an online database, accessible to practitioners through the MDC website.

EVENT/TITLE:……

Is it multidisciplinary or single subject (please underline relevant answer)

Start Date: _ _/_ _/_ _ Finish Date: _ _/_ _/_ _ Duration (days)……..……

Name of Venue:……..……..

Venue Locality:……..……

If this event is repeated and has no change to the programme or to the speakers, please add additional dates and venues below

Date(s)…… Venue:……..……..

Fee(s) to be charged to the delegates:……..……..……..

Number of hours (excluding break times): …… Max 6 per day

Provider Organization:……

Contact Name:……

Contact E-mail:…… Contact Tel. Number:……

Target Audience

Target Audience – Professional Roles (*Tick all that apply*)

__Consultants and Specialists

__Training Grades

__Other ……

[Please note that events aimed primarily at training grade physicians, residents or non medical health professionals do not qualify for verifiable CPD credit approval.]

Target Audience – Geographical Area
__International
__ National
__ Regional

<u>Clinical Events</u>: Medical and Dental Specialties (*Please tick all that apply*)

Medicine
Indicate sub-specialty……

Surgery
Indicate sub-specialty……..

Child Health
Indicate sub-specialty……..

Obstetrics and Gynaecology
Indicate sub-specialty……..

Family Practice
Indicate sub-specialty……..

Dental
Indicate sub-specialty……..

Other……

Non-Clinical events (*Please tick as appropriate*)

__ Education & Training
__ Health Service Policy / Management
__ Ethics
__ Other……

Financial Declaration

Name(s) of sponsor(s) if not Provider organization:……..

Educational Details

Please list the Learning Objectives for the event below. The objectives should reflect measurable outcomes, and use action verbs such as “evaluate”, identify”, “review”, etc. For example, “To evaluate current guidance regarding the application of the Mental Capacity Act, in order to increase practitioners’ awareness of this topic”.

1. ……

2. ……

3. ……

4. ……

5. ……

Which teaching methods will be used? (*Please tick as appropriate*)

__ Lectures
__ Tutorials
__ Discussion Group
__ Practical
__ Quizzes
__ Demonstrations
__ Workshops
__ MCQs
__ Other (*Please specify*)……

How will the event be evaluated?.....

……

Check Lists

CPD providers of approved events are required:
__ To keep a record of the names of the people who attended.
__ To provide attendance certificates to participants
__ To provide evaluation forms to the delegates.
__ To have read the Guidelines for Providers

Have you included in your application?
__ A full programme of the meeting, including an hourly breakdown and details of the sessions.
__ A complete list of the speakers including information about what posts they hold, where they are based and what speaking experience they have, particularly in relation to the topic to be presented. This is especially important for non-clinical topics.
__ All the sections in this application form and the required fee

Correspondence Details

If you wish your correspondence details to be different from those in the first section, please give details below:

Name: ……..

E-mail: …… **Tel**: ……..

Address: ……

……

Completed application form and programme should be sent to:

The Registrar,
Medical and Dental Council,
P.O. Box AN 10586, Accra, Ghana.
MDC House, Adjabeng, Accra.

For Office Use Only

This event is approved for Verifiable CPD credits for the year 200___

Fee Payable for Event:……...

Mode of Payment: Cheque No:…… **Cash**: ……

Received by:..... **Date**: _ _/_ _/_ _

CPD credits for full Attendance: …… **Verifiable**:……..

Non Verifiable:…… **Event Code Number**:……

Director's Comments:.....

.....

Signature:..... **Date**: _ _/_ _/_ _

Additional Comments:……

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