## C:\Users\Adam\SkyDrive\Work file\AFMS\Logos\AFMS Logo without background.gif

## Academy of Forensic Medical Sciences

#### Continuing Professional Development (CPD) Accreditation Application Form

**2018**

*Special dispensation will, from time to time, be made for some providers when completing this form. Academy of Forensic Medical Sciences will take into consideration the type of provider submitting a request as it is recognised that, on occasion, not all areas of the form are entirely relevant to every organisation.*

This form should be used when applying to the Academy of Forensic Medical Sciences for CPD accreditation and to determine the number of CPD hours that are merited by the activity in question. Further details regarding the CPD accreditation can be found on the Academy website: [www.afms.org.uk](http://www.afms.org.uk).

This information will be used both as a definitive printed description for validation purposes, and as a record held by the Academy of Forensic Medical Sciences. A reference copy of all event descriptions will be held in the Academy office. **If any of the information provided in this form changes, then please submit an updated form electronically to:** **info@afms.org.uk** **as soon as possible.**

|  |
| --- |
| **Providing Organisation:**      |
| **Correspondence Address:**      |
| **Contact Name:**      **Contact email:**      **Contact telephone number:**       |
| **Event / Presentation Title**       |

|  |
| --- |
| **CPD Hours***(Total number of hours)*      |

|  |
| --- |
| **Details of Speaker (s) / Trainer (s) and the Event Co-ordinator**       |

|  |
| --- |
| **Description and Brief Synopsis of the event**      |
| **Aims and Objectives** *(What is the training aiming to achieve?* The objectives should reflect measurable learning contents and be relevant to the target audience.*)*      |

|  |
| --- |
| Target Audience: (suitability and range of specialism/discipline)      |

|  |
| --- |
| **Financial and Conflict of Interest Declaration****Please provide details of any potential conflicts of interest below specifying nature of potential conflict, steps taken to manage conflict and 3rd parties involved.** (i.e. sponsors or content providers)      |
| **Company:**       | **Role:**       |

|  |  |  |  |
| --- | --- | --- | --- |
| Date & Time of delivery xx.xx.20xx – xx.xx.20xx | **Date(s)**      | **Start Time(s)**      | **End Time(s)**      |
| Venue       |
| Length of the event (In hours - excluding registration/refreshment breaks) |       |

|  |
| --- |
| Cost to Delegates (excl. VAT)      |

|  |
| --- |
| Recurring Event*Is this event a repeat e.g. has it received CPD accreditation previously in the same calendar year?*      |

|  |
| --- |
| Delivery Methods, course materials/resources (Lecture, Seminar, Conference / Symposium, Distance Learning (specify), Other (specify))      |

|  |
| --- |
| **Course Materials/Resources** (brief details)      |
| **Is there an Assessment?** (brief details)Yes      No       Further information:       |

|  |
| --- |
| Quality Assurance Evaluation  |
| How do you intend to monitor the training/event delivered? (brief details)      |
| How will you gather, retain and evaluate feedback from participants? (brief details)      |
| The number of people likely to attend      |

**Declaration on Conflict of Interest**

I have read and understood the Academy of Forensic Medical Sciences’ guidelines regarding the conflict of interest and declared and submitted all information about any potential conflict of interest in accordance with these guidelines.

I confirm the details in this application are true and accurate to the best of my knowledge, and I will comply with the requirements of the Academy of Forensic Medical Sciences’ Approval Scheme.

**Form completed by:**

**Name: Date: xx/xx/20xx**

**Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For Completion by Academy of Forensic Medical Sciences

|  |  |
| --- | --- |
| Date of receipt of application:Reference: |  |
| Date sent to the CPD Sub-Committee: (if applicable) |  |
| Date of approval: |  |
| Approved by: (Secretariat / Committee) |  |

Authorisation

**On behalf of the Academy of Forensic Medical Sciences**

**Name: ………………………………………………………….. Date: ………………….**