

School of Pharmacy

Continuing Pharmacy Education

Reviewer Evaluation Form

After reading the submitted materials, complete the form below and return by email with any comments/changes that you might have.

Mission Statement:

*The Office of Continuing Education will provide quality continuing pharmacy education to pharmacy practitioners in formats that are both accessible and functional, address their current and emerging practice need and ensure continued competence and awareness of current trends in pharmacy practice.*

***The Title***

Does the title correctly represent the content? Yes  No

***Targets (Select all that apply).***

This article is appropriate for: Pharmacists  Pharmacy Technicians

**The activity………..**

Is designed to meet our mission Yes  No

Has a clear purpose. Yes  No  Addresses an emerging need Yes  No

May help improve competence Yes  No

***Practice gaps and related needs. Note: the practice gap = difference between current practice and desired practice.***

Practice gap identified Yes  No  Practice gap is documented Yes  No

**Supporting documentation/explanation (choose all that apply)**

Lit. Review  Expert opinion  Govt report/guidance  Practice guidelines

New developments  None  Other (please type in)

***Expected Outcomes***

The activity may result in a change in (select all that apply)

Competence  Performance  Patient Outcomes

***Independence from Commercialism***

The content has an educational rather than a promotional purpose? Yes  No

Product names used appropriately (generic names)? Yes  No  N/A

The content is fair, balanced and objective? Yes  No

Generic drug names are the primary names used throughout the activity Yes  No  N/A

***Length of Time to complete:***

How long would it take for a pharmacist to complete this activity?

30 minutes  1 Hour  2 hours  Other (please type in)

***Revisions***

I have included revisions to the content that must be addressed Yes  No

If you have revisions you would like addressed, please include them in the space below or add an attachment:

**Conflict of Interest Declaration - Reviewers**

The Office of Continuing Pharmacy Education requires that all involved in controlling content in a CPE activity must disclose any relevant commercial of interest. Complete and return this form after reviewing the CE activity. ***You must disclose all commercial interests to participants prior to the activity.***

**Activity Title:** Click or tap here to enter text.

**Reviewer Name:** Click or tap here to enter text.

**PART 1: TO BE COMPLETED BY REVIEWER (read ACPE guidelines on non-commercialism)**

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| I have no actual or potential conflict of interest in relation to this activity.  I have a financial interest/arrangement, affiliation or relationship 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 activity, including but not limited to:     |  |  |  | | --- | --- | --- | | **C** | **CATEGORY** | **Description (Names of Organizations and Relationship)** | |  | Employee |  | |  | Royalty |  | |  | Stockholder |  | |  | Research Support |  | |  | Speaker’s Bureau |  | |  | Consultant |  | |  | Other financial or material interest |  |   I understand the above information will be disclosed to the audience in advance of the activity verbally (for live activities) and in print. My disclosure provided above is accurate for the past 12 months. All recommendations involving clinical medicine in my presentation are based on evidence that is accepted within the health profession as adequate justification for their indications and contraindications in the care of patients. All scientific research referred in, reported, or used in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection, and analysis.  I understand that I must submit activity materials (i.e. slides, handout, home study activities) at least 3 weeks in advance of the event so that they may be reviewed for conflict of interest/potential bias.  *Signature* Click or tap here to enter text. *Date*Click or tap here to enter text.  I confirm that my typed name serves as my electronic signature. Yes No |

**PART 2. TO BE COMPLETED BY CPE DIRECTOR**

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| If conflict of interest are present, the conflicts were resolved by the following process (check one):  Peer review  Individual ended relationship  Selected an alternative reviewer  Other\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Accepted by/date Click or tap here to enter text. |

**PLEASE EMAILTHE COMPLETED FORM TO:**

Walter Siganga, RPh., PhD. Director, Continuing Pharmacy Education. SIUE School of Pharmacy.

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