

VISTAKON®, division of Johnson & Johnson Vision Care, Inc.

Eligibility Questionnaire for Accredited Providers and Educational Partners

**For Grant Requests for CME/CE Certified Activities**

**Each organization directly involved in CME/CE certification or content development for the proposed independent medical education activity(s) must complete an Eligibility Questionnaire**

**Section I. Grant Applicant Information**

1. For this grant application, is this organization the:

**Accredited Provider** – Has responsibility for the compliance of the proposed activity. Engaged in or representing healthcare professionals who provide direct patient care (Includes Schools of Optometry, Schools of Medicine, and National, Regional, and State Medical and Professional Societies and Associations, etc).

If you are applying as the Accredited Provider, list any Educational Partner(s) (maximum 250 characters)



**OR**

**Educational Partner(s)** – Joint Sponsors or Co-Sponsors. All other organizations involved in the planning and development of the proposed educational activity.

If you are applying as an Education Partner, list the Accredited Provider (maximum 250 characters)



1. Organization information

Name (as listed on W9)

Company address

Company address 2

City

State  Zipcode

1. Primary Contact from this organization for this application

Name, Position/Title

Phone

Fax

email

1. Is this primary contact authorized to sign Educational Grant Agreements (EGA)Yes No

If no, please provide contact information for the individual authorized to sign EGAs

Name, Position/Title

Phone

Fax

email

1. **For this grant application,** in what therapeutic area are you are seeking funding
2. Please provide up to 3 examples of completed educational activities **in the therapeutic area relevant** to this grant application (preference for activities that have completed within the last 24 months)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Activity Title**  **(100 character limit)** | **Type of Activity** | **Activity date(s)**  **(m/d/yy-m/d/yy)** |
| 1 |  |  | **–** |
| 2 |  |  | **–** |
| 3 |  |  | **–** |

**Section II. Current Ownership Structure and Conflict of Interest Assessment**

1. Which classification best describes this organization?

Other (describe)

1. Are there any prior or current relationships between key staff members or owners and Johnson & Johnson Vision Care, Inc (JJVCI)? Yes No

If yes, please specify organizational size and associated ability to remove from participation in certified independent educational activities any individuals with potential conflicts of interest

1. Does this company have a parent organization? Yes No [**If No, click here to skip to Section III.**](#Text1)

**a.** If yes, please provide the following parent organization information

Name (as listed on W9)

Company address

Company address 2

City

State  Zipcode

**b.** Is the parent organization a commercial interest as defined by the ACCME? (e.g., a commercial interest is any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients)

Yes No Not Applicable

**c.** In the past 12 months, has any subsidiary or affiliate company been involved in providing or supporting company-directed services for pharmaceutical companies, medical device manufacturers, nutraceutical or herbal supplement companies, etc., including but not limited to advertising/promotional services, publication planning, speaker bureau management, speaker training, and advisory board/consultant meeting planning?

Yes  No Not Applicable

**Section III. Accreditation Information for This Grant Application**

1. Is this organization providing CME/CE certification for any activity associated with this grant application?

Yes  No [**If No, click here to skip to Section V.**](#Text6)

1. With regards to this grant application, for which healthcare professional audience(s) is the activity intended to be CME/CE certified (check all that apply): Optometrists Ophthalmologists Opticians Paraoptometrics Ophthalmic Technicians
2. Which regulatory bodies recognize this organization as an accredited provider or a designated approver of certified independent education for the healthcare professionals described above? Select all that apply and the expiration date and accreditation duration.

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| --- | --- | --- |
| **Name of Regulatory Body** | **Expiration date of current accreditation or approval status (MMM – YY)** | **Length of term**  **(# of years)** |
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|  |  |  |
|  |  |  |
| Other: |  |  |

**For ACCME accredited providers**:

1. Please provide accreditation level (check one box)

accreditation  accreditation with commendation  probation

provisional accreditation non-accreditation  Not applicable

**For ALL accredited providers:**

1. Within the previous 12 months, has this organization been asked to respond to a complaint or inquiry about an educational activity? Yes No

If yes, please describe the nature of the situation.

1. Within the previous 12 months, has this organization been placed on probationary status by an accrediting organization? Yes No

If yes, please describe the nature of the situation.

1. Within the previous 12 months, has this organization been found to be in partial compliance or non-compliance by an accrediting organization? Yes No

If yes, please describe the nature of the situation.

***If there were findings of partial compliance or non-compliance a copy of any written communications from the accrediting agency noting that the corrective action plan is acceptable is required prior to the review of this grant application.***

**Section IV. Compliance Questions for Primary Accredited Provider Only**

***JJVCI may require examples as a condition for providing educational grant funding***

1. Is this organization applying as the Accredited Provider for this grant application **as described in Section I**?

Yes  No [**If No, click here to skip to Section V.**](#Text6)

1. Does this organization have a written policy regarding the identification and resolution of potential conflicts of interest between potential faculty members and the commercial supporter(s)? Yes No

If no, please explain.

1. Does this organization have adequate staff to provide a detailed accounting and documentation of the disbursement of grant funds, on a timely basis, if requested by the grantor? Yes No

If no, please explain.

1. Does this organization have a Compliance Officer? Yes No

If no, please explain.

1. Does this organization have written policies/procedures covering the following specific risk areas:
2. Communications with grantors

Yes No If no, please explain.

1. Interactions with faculty including honoraria and travel reimbursement and documentation to ensure faculty will comply with the conditions of appropriate use of commercial support

Yes No If no, please explain.

1. Does this organization have the following written compliance policies/processes in place:
2. Adequate staff training and documentation of ongoing education around compliance and CME, including outgoing communications for organizational staff

Yes No If no, please explain.

1. A process for handling employee, attendee and accreditation agency complaints

Yes No If no, please explain.

1. A process to monitor and periodically assess organizational systems for compliance with grant agreements with commercial supporters

Yes No If no, please explain.

1. Written policies describing disciplinary actions that can arise from breach of compliance requirements

Yes No If no, please explain.

1. Does this organization require that participants rate the educational activity with regards to fair-balance and independence as a whole and for individual faculty? Yes No

If no, please explain.

1. Please provide a summary of fair balance and commercial bias assessments/ratings for the last 3 educational activities certified by this organization

|  |  |  |
| --- | --- | --- |
| **Activity Title**  **(max 150 characters)** | **Type of Activity** | **Summary of participant assessment of bias**  **(max 150 characters)** |
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|  |  |  |
|  |  |  |

Other:

Section V. CERTIFICATION OF SEPARATION

(Required for all Accredited Providers and Educational Partners)

**(I)** I, **Name, Job Title**, of ***Accredited Provider or Educational Partner,*** hereby certify that:

***Accredited Provider or Educational Partner*** is not now, and has not been at any time during the last twelve months, involved in providing or supporting advertising or other company-directed activities to Johnson & Johnson Vision Care, Inc. in the same therapeutic area as proposed in the accompanying grant application. Company-directed activities include, but are not limited to, advertising/promotional services, advisory boards/consultant meetings, promotional speaker’s bureaus and publication planning.

# OR

*[If this company is part of a larger organization that owns another company (ies) that has handled commercial or other company-directed activities for* Johnson & Johnson Vision Care, Inc. *within the last 12 months]*

**(II)** I, **Name, Job Title**, of ***Accredited Provider or Educational Partner***, herby certify that:

***Accredited Provider or Educational Partner*** is not now, and has not been in the past 12 months, involved in providing advertising or other company directed activities or services to Johnson & Johnson Vision Care, Inc. in the same therapeutic area as proposed in the accompanying grant application. Company-directed activities include, but are not limited to, advertising/promotional services, advisory boards/consultant meetings planning, promotional speaker’s bureaus and publication planning.

***Accredited Provider or Educational Partner*** is owned by ***Parent Company***. ***Parent Company*** also owns ***Commercial Vendor***, a company that is or has been involved during the past 12 months in commercial or other company directed activities for Johnson & Johnson Vision Care, Inc.

***Accredited Provider or Educational Partner*** is a separate legal entity from ***Commercial Vendor***, and has a separate tax identification number from ***Commercial Vendor***.

***Accredited Provider or Educational Partner*** does not share office space with ***Commercial Vendor***.

The account management, editorial, sales, project planning personnel and medical advisors, both employees as well as outside consultants, of ***Accredited Provider or Educational Partner*** are distinct and separate from the account management, editorial, sales, project planning personnel and medical advisors of ***Commercial Vendor***.

***Accredited Provider or Educational Partner*** does not have access to records or computer systems impacting on program content or project-related content maintained by ***Commercial Vendor***.

Employees of ***Accredited Provider or Educational Partner*** do not and will not engage in communications with employees of ***Commercial Vendor*** regarding Johnson & Johnson Vision Care, Inc. promotional strategies or company-directed activities.

**Section VI. Required Signatures**

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| --- | --- |
| ***If any of the above information changes, I will notify JJVCI immediately.***  **Accredited Provider OR Educational Partner** | |
| **Name, Title, Date** | **Name, Title, Date** |

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| --- | --- |
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| --- | --- |
| Signature of CME/CE Compliance Officer or Director | Signature of President or CEO or CME/CE Director |