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Advances and Controversies in Clinical Nutrition Conference
OFFICIAL EDUCATIONAL SATELLITE SYMPOSIUM APPLICATION

Please first review the Official Educational Satellite Symposium Guidelines (CLICK HERE) before completing this application. To be considered for approval for an Official Educational Satellite Symposium, please complete this application and return it electronically by using the SUBMIT button. The SUBMIT button will open an e-mail with the application data attached. You should also select the PRINT button to print a copy for your records. At that time also attach any other files needed to complete the application for each Official Educational Satellite Symposium to be supported in conjunction with the "Advances and Controversies in Clinical Nutrition Conference". Incomplete applications will not be processed. There should be ample room within the electronic text boxes below to supply required information. However, if you need additional space, please attach any additional data in a Word format and clearly label the section to which it belongs.

You may want to consider CME/CE credit for physicians and other allied health professionals who may attend this program.

Deadline to be included in the Course Book – December 1, 2010

ASN has designated the following dates and times for satellite symposia programs

FRIDAY	SATURDAY	SUNDAY
February 25	February 26	February 27
7 am – 1:45 pm	5 a.m. – 7:45 am	5 am – 7:45 am
7:15 pm – 10 pm	7 pm – 10 pm	12:15 pm – 5 pm

Contact Information

Grantor / Commercial Supporter: _____

Required field – Please refer to Page 2 of the Symposium Guidelines for definition

If there are multiple supporters, please attach a separate list.

Contact Name: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email: _____

If CME/CE credit is to be offered, please provide the appropriate provider accreditation statements where indicated to confirm that the program is designated for AMA Category 1 CME credit or CE certification.

Responsible CME/CE Accredited Provider/Sponsor: _____

Required field – Please refer to Page 2 of the Symposium Guidelines for definition

Contact Name: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

Email: _____

Please list any additional contacts who should receive information pertaining to the symposium, if not listed above.

Name: _____ Name: _____

Organization:_____ Organization:_____

Tel: _____ Tel: _____

Email: _____ Email: _____

Third Party Planner: _____

Please refer to Page 2 of the Symposium Guidelines for definition

Contact Name: _____ Title:_____

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

Email: _____

Program Information

Check intended participants (select all that apply): Required

❑ Physician ❑ Nurse ❑ Nurse Practitioner ❑ Physician Assistant

❑ Pharmacist ❑ Dietitian ❑ Nutritionist ❑ Diabetes Educator

Title of Symposium: _____

Required

Abstract Summary of Symposium: *description provided will appear in printed materials.* Required

Proposed Symposium/Agenda/Faculty (include names, titles, affiliations) Required

Summary of Needs Assessment: Required

Evaluation Process: Provide a description of the evaluation/outcome measurement process as related to the summary of the **Needs Assessment** and **Learning Objectives** Required

Learning Objectives: Provide symposium objectives as related to the summary of the Needs Assessment **Required**

Check the types of credit the symposium will offer: **Required**

❑ CME Credit
❑ CE Credit
❑ Other _____

Accreditation Statement: If CME/CE or other certification is to be offered, provide a statement that the symposium is designated for AMA/PRA Category 1 credit or for appropriate CE or other certification for allied healthcare professionals. **Required**

Symposium/Course Director (include names, titles, affiliations): **Required**

_____

Faculty List (include names, titles, affiliations): **Required**

❑ Indicate that disclosure statements will be obtained from all faculty.

Disclosure Statement: (provide a sample disclosure statement) **Required**

Scheduling Information

Preferred Date and Time: (indicate your preferred choice below. ASN will do its best to accommodate your request, but cannot guarantee that the preferred time slot will be assigned) **Required**

Registration and modest meal functions for all satellite symposia are permitted to begin no more than fifteen minutes prior to the start of the symposium, but may continue after it has begun.

____ Friday, February 25: 7:00 am – 1:45 pm, ____ 7:15 pm- 10:00 pm
____ Saturday, February 26: 5:00 am – 7:45 am, ____ 7:00 pm – 10:00 pm
____ Sunday, February 27: 5:00 am – 7:45 am, ____ 12:15 pm – 5:00 pm

Preferred Function Location: ASN will assign first-approved meeting space.

Anticipated Attendance: **Required** _____

Beginning Time (including registration): (if later than indicated above) _____

Ending Time: (if earlier than indicated above) _____

Set-up Start Time: _____ **Estimated Completion Time:** _____ **Date:** _____

Tear-down Start Time: _____ **Estimated Completion Time:** _____ **Date:** _____

Function Type: (please check all that apply)

- ❑ Education with Breakfast
- ❑ Education with Dinner
- ❑ Education with Reception
- ❑ Education with Dessert Only
- ❑ No Food Function

Room set-up: Required ❑ Schoolroom ❑ Theater ❑ Rounds ❑ Crescent Rounds ❑ Other _____

If A/V will be used, type of projection required: Required ❑ Front ❑ Rear ❑ Other _____

Approximate time necessary for production/audio visual set: _____

Provide any additional details regarding requirements not covered above.

Online Registration

Web Address or Email address for attendees to obtain more information or to register for the symposium:

_____

Signature Information

Date: _____

Organization: _____

Signature: _____

Electronic Signature:

_____ **PRINT NAME THEN CHECK THIS BOX** ❑

CHECKING THIS BOX INDICATES ACKNOWLEDGEMENT THATTHE ELECTRONIC SIGNATURE IS A BONAFIDE SIGNATURE AUTHORIZATION

Administrative Fee Information (Also refer to "Administrative Fee" in the Guidelines.)

The administrative fee outlined below for holding an Official Educational Satellite Symposium is due within 30 days after ASN approves the application. Please make checks payable to: American Society for Nutrition and send to: Blackwood CME, 900 Route 168, Suite A-2, 1st Fl, Blackwood, New Jersey, 08012. A confirmation letter will be sent upon approval of the satellite symposium.

Check appropriate fee. Required

Administrative Fee Structure

Exclusive - ***No other program will be scheduled in the same time slot.***

- ❑ **Friday AM - $13, 000**
- ❑ **Friday PM - $22,500**
- ❑ **Saturday AM - $20,000**
- ❑ **Saturday PM - $22,500**
- ❑ **Sunday AM - $20,000**
- ❑ **Sunday PM - $13,000**

Non-exclusive - ***Other program(s) may be scheduled in the same time slot.***

- ❑ **Friday AM - $13,000**
- ❑ **Friday PM - $18,000**
- ❑ **Saturday AM – $15,000**
- ❑ **Saturday PM - $18,000**
- ❑ **Sunday PM - $13,000**

NOTE: Sponsors of more than one symposium will receive a discount of 5% on the total symposia fees due.

Submission Information

Reminder: Please review the Official Educational Satellite Symposium Guidelines before submitting this application.

PLEASE NOTE

Please contact Brent Schwartz at Blackwood CME if you experience a problem with the electronic submission of this application: (856) 481-4805 ext. 25

Blackwood CME
Washington Professional Campus , 900 Route 168, Suite A-2, 1st Fl. Blackwood, NJ 08012
Tel: (856) 481-4805
E-mail: brent.schwartz@BlackwoodCME.com