**Joint Providership Activity Agreement:**

This agreement is between the American Society for Metabolic and Bariatric Surgery (ASMBS) and **[****Organization Name]**, a State Chapter of the ASMBS.

By its authorized signature on this agreement **[****Organization Name]** affirms that its CME activity serves to develop/maintain the knowledge competence and/or performance that a physician uses to provide services for patients. Further, the **[****Organization Name]** accepts accountability for all aspects in the planning and implementation of these CME activities in compliance with the Accreditation Council for Continuing Medical Education (ACCME) Accreditation Criteria and ACCME Standards for Integrity and Independence in Accredited Continuing Education.

ASMBS and **[****Organization Name]** agree to the following:

* + 1. Planners’ disclosures must have been submitted to ASMBS prior to the planning of this activity in order to be in compliance with ACCME regulations.
    2. It is the responsibility of the chapter to inform learners that speakers and those in control of content provided appropriate disclosure prior to the activity.
    3. All proposed CME activities must be reviewed and approved by the ASMBS CME Compliance Manager to ensure compliance with ACCME accreditation criteria
    4. ASMBS, as the ACCME-accredited provider, will assign the appropriate *AMA PRA Category 1 Credit™*. Further, ASMBS shall have the authority to withdraw the designation of credit and revoke this Agreement at any time during the planning or implementation of the activity if the **[****Organization Name]** fails to meet the requirements of the ACCME or the terms of this Agreement.
    5. **[****Organization Name]** shall comply with all deadlines pertaining to the completion and transmission to the ASMBS of all required forms and data pre- and post-activity.
    6. All commercial support for the activity is subject to approval of the ASMBS.
    7. All Letters of Agreement (LOA) pertaining to educational grants and sponsorships must be approved and signed by ASMBS prior to the start of the activity.
    8. All monies from commercial supporters should be paid directly to the **[****Organization Name]**. **[****Organization Name]** shall provide ASMBS with a copy of the finalized agreement and a post- activity accounting as to how the funds were disbursed. In the event the supporter requires the check be payable to ASMBS, the check will be reissued by the ASMBS to the **[****Organization Name]** minus a 5% administrative fee.
    9. All promotional materials (brochures, advertisements, flyers, syllabi, and website information) must be approved by ASMBS in writing prior to being distributed.
    10. Accreditation of the proposed CME activity may not be advertised prior the ASMBS approval.
    11. **[****Organization Name]** agrees to indemnify and hold harmless ASMBS against any claims or expenses arising from the educational activity.

**Fee schedule to ASMBS as follows:**

Application fee of $200 is nonrefundable and must accompany the completed State Chapter Joint Providership Activity Agreement. *Select how this fee will be submitted.*

Credit Card Form (below)

Check (Mail to: ASMBS 14260 W. Newberry Road #418 | Newberry, FL 32669)

A fee of $200 per assigned maximum credit for the activity is payable 30 days after approval of activity.

Once your Joint Providership Activity Agreement is approved you will receive an email from the ASMBS Compliance Manager that will contain instructions, the full CME application, and required documents.

**For the ASMBS:**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print (Type) Name:** **Date:**

**Title:**

**[****Organization Name]:**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print (Type) Name:       Date:**

**Title:**

**ASMBS Credit Card Authorization Form**

**Name:**

**Date of submission:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Credit Card to be charged for the following:**

$200 Joint Providership Application Fee

$200 per assigned maximum credit for the activity

Enter total credits offered for the activity:

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**Visa**  **Mastercard**  **American Express**  **Discover**

**Card Holder:**

**Card Number:** **CVV Code:**  **Expiration:**

**Billing Address:** **City:** **State:** **Zip:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address to send the receipt:**

**Billing Address**  **Email:**

**I agree to the charges listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**