Please read the information and criteria [document](https://ca.gsk.com/media/1270575/info-and-criteria-en.pdf) on the GSK Canada independent medical education (IME) website. If any of these criteria has not been met, your grant application will not be eligible for funding. To apply, please complete, sign, and email this form and any other supporting documentation to **ca.medical-education@gsk.com**. For any enquires please contact our email with your questions or set up a call with our team. You may also refer to our [FAQ](https://ca.gsk.com/media/1334058/faq-en-01aug2017.pdf).

|  |  |
| --- | --- |
| **Application Sections** | |
| 1. IME Provider Details 2. Program Information 3. Therapy Area 4. Identified Healthcare Professional Need | 1. Educational Design and Outcomes 2. Budget 3. Declarations and Signature |

Application Checklist

|  |  |
| --- | --- |
| 1. **IME Provider Details**: Your organization is an eligible IME provider\* per GSK requirements. \**Eligible providers include scientific or professional organizations; professional medical, pharmacy and nursing societies; patient advocacy groups, patient centered organizations; university faculties; integrated health networks and health authorities; and hospital departments or divisions. Ineligible providers include individual healthcare professionals (HCPs) or small working groups of HCPs, for-profit online education, publishing or communications companies and similar ventures, or non-Canadian organizations.* |  |
| 1. **Program Information:** The initiative must be held in Canada. The event's start date is no earlier than **8 weeks (about 2 months)** after the date the application is submitted, or the deadline of the current submission cycle. Providers can attest that their grant request (in addition to any other grant funding from GSK) does not represent more than 25% of the total funding received by the Recipient during the current calendar year. It is recommended to be concise in the application and append any specific details separately. |  |
| 1. **Therapy Area**: Proposal is in a GSK disease area of interest for the current funding year. Topics or product specific data that is shared during the program (whether related to GSK or non-GSK products), must be in accordance with the product approved indication for any product (including class, mechanism of action, or disease area education). |  |
| 1. **Identified HCP Need**: Proposal includes an evidence-based education needs assessment. |  |
| 1. **Educational Design and Outcomes:** Proposal includes detail on the design of the education initiative and seeks to measure educational outcome(s) that meet GSK criteria for funding. The target audience is composed of healthcare professionals. |  |
| 1. **Budget:** Budget is customary, itemized, and aligned to appropriate categories. |  |
| 1. **Declarations and Signature:** Provider agrees to GSK’s requirement for transparency and right to disclose details of IME grants. Provider willing to provide an executive summary of the education provided and the aggregate educational outcomes achieved. Disclosed information and executive summary may be made publicly available on GSK’s external website. Conflicts of interest have been sought and disclosed. |  |
| Education development is free from commercial influence and content is non-promotional, fair, and balanced. The program does not offer commercial benefits or opportunities for funders\*  \**If the intent of the sponsorship request is to offer any sort of commercial benefits (e.g., booth or complementary conference registration) in exchange for sponsorship, the request will be assessed by the conference sponsorship team and should be submitted to their group mailbox, ca.conference-sponsorship@gsk.com. This form does not have to be completed.* |  |

1. IME Provider Details

|  |  |  |
| --- | --- | --- |
| Name of organization |  | |
| Type of organization | Scientific or professional organization  Professional medical, pharmacy, or nursing society  Patient advocacy group, patient-centered organization  University Faculty  Integrated Health Network or Health Authority  Hospital department or division  Other; please specify: | |
| Is your organization a healthcare organization (HCO)?  *Please note that both HCOs and non-HCOs can be eligible. This information is for our internal records and processes and does not impact the funding decision.* | Yes  No  *HCO: A legal entity that is a healthcare, medical or scientific association or organization such as a hospital, clinic, foundation, university, or other teaching institution or learned society (except for patient organizations).* | |
| Is your organization for-profit?  *Ineligible organizations include for-profit online education, publishing or communications companies and similar ventures.* | Yes No | |
| Description of organization  *Please include a* ***brief~200****-word description of your organization’s governance structure and purpose. Feel free to include links or attachments to your application to provide more background about your organization.* |  | |
| Payable name and address (if application is approved)  *Please note that GSK cannot remit funds to a third-party vendor or an individual; funds must be remitted only to the requesting organization.* | Name |  |
| Address |  |
| Preferred method of payment (if application is approved) | Cheque  Electronic funds transfer (EFT) | |
| Contact name and address for business correspondence and payment | Name |  |
| Address |  |
| Email |  |
| Telephone |  |

1. Program Information

|  |  |
| --- | --- |
| Title of the educational initiative |  |
| Total amount of funding requested  \*Note: There are three annual calls for proposals during which applications can be submitted: January, May, and September.  \*Note: Only includes the amount requested from GSK, and not the total cost of the initiative (if partial funding). | $ |
| Is the amount requested more than 25% of your organization’s annual revenue? | Yes  No |
| Will there be industry sponsored booths at the event? | Yes No |
| City/Province/Country of Session |  |
| Start date of educational initiative\* |  |
| End date of educational initiative\* |  |

\*Please Note: The event start date should be at least **8 weeks** after the application is submitted, or the deadline of the current submission. Applications submitted with less than an 8-week period may be rejected. If there are multiple sessions, please list the earliest start date and latest end date.

|  |  |
| --- | --- |
| Brief description of the educational initiative (**maximum ~150 words**) |  |

1. Therapy Area

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Educational proposal is in the following GSK therapy area(s):** | | | | |
| **Respiratory** | **Vaccines** | | | **Oncology** |
| Asthma  COPD | Pediatric immunization  Adult immunization | | | Ovarian cancer |
| Disease area (if applicable): | | |
| Diphtheria  Haemophilus influenzae B  Hepatitis A&B  Influenza  Measles  Mumps  Neisseria meningitides  Human papillomavirus | | Pertussis  Polio  Rotavirus  Rubella  Streptococcus pneumonia  Tetanus  Varicella  Herpes zoster |
| Across Diseases & Technologies, General Vaccine Science | | |
| Vaccine Hesitancy  Adjuvants | Vaccine Education  Other; please specify: | |  |

1. Identified Healthcare Professional Need

|  |
| --- |
| **What is the educational need or gap in healthcare professional knowledge/competencies that your program addresses?** |
|  |
| **How was this educational need determined?** *e.g., review of literature, expert interviews, healthcare professional survey data, national census data, regional or national governing body recommendation* |
|  |

1. Educational Design and Outcomes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **What is the format of your educational program?** *e.g., online module, seminar, in-person session with case scenarios, workshop, campaign, conference symposium, etc.* | | | | |
|  | | | | |
| **IME grants are intended to support healthcare professional education, not patient education.** **Please describe the estimated number and role of the target audience for this educational program**. | | | | |
| **Number** | **Role** | | **Additional notes on target audience (if applicable):** | |
|  | Specialist | |  | |
|  | Family physician | |
|  | Nurse | |
|  | Pharmacist | |
|  | Allied health care professional (e.g., respiratory therapist, public health epidemiologist) | |
|  | Other: please specify | |
|  | **Total Number of Attendees** | |
| **Please provide an outline of the program content and agenda (add attachment if applicable).** *If your agenda is not yet finalized, please submit a draft. If your program is an individual session that is part of a larger program or conference, please provide the agenda for only your program, and not the entire conference.* | | | | |
|  | | | | |
| **List the learning objectives/outcomes of the educational program:** | | | | |
|  | | | | |
| **How will these educational objectives/outcome(s) be measured and/or analyzed?***e.g., pre and post-test, follow-up with participants, patient health records, questionnaires, etc.* | | | | |
|  | | | | |
| **Please select the level(s) that best apply to your educational outcome1(s) from the table below.** *Note that the outcome must be at or above level 3a to be eligible.* | | | | |
| **Education Outcome Level** | | **Description** | **Example of measurement/analysis of outcome** |  |
| **Level 7**:  Community Health | | The health status of a community of patients changes due to changes in the practice behaviour of participants | *Analysis of patient/community health records* |  |
| **Level 6**:  Patient Health | | The health status of patients improves due to changes in the practice behaviour of participants | *Analysis of patient health records* |  |
| **Level 5:**  Performance | | Participants can ***do*** what the educational program intended them to be able to do in their practices | *Follow-up or check-in with participants to check if practice behavior has changed* |  |
| **Level 4**:  Competence | | Participants can ***show*** in an educational setting how to do what the educational program intended them to be able to do | *Case study response or role-play demonstration* |  |
| **Level 3b**:  Learning procedural knowledge | | Participants can ***state*** ***how*** to do what the educational program intended them to know how to do | *Pre and post-test* |  |
| **Level 3a**:  Learning declarative knowledge | | Participants can ***state*** ***what*** the educational program intended them to know how to do | *Pre and post-test* |  |
| **Level 2**:  Satisfaction | | Expectations of the participants about the settings and delivery of the educational program were met | *Participant satisfaction survey* |  |
| **Level 1**:  Participation | | The number of physicians and others who participated in the educational program | *Attendance records* |  |

1Please refer to Moore D.E., J*ournal of Continuing Education in the Healthcare Professions*, 2009, vol. 29, issue 1, page 4.

1. Budget

|  |  |
| --- | --- |
| * Honoraria & faculty expenses may be included. * Participant travel or out-of-pocket expenses will not be eligible for funding consideration. * For personnel costs, please include a known or estimated hourly or daily rate and the number of hours or days of expected work. * All costs in the budget should be pre-tax. | * Post-activity budget reconciliation may be requested for applications to confirm the appropriate use of educational funds. * We require a full breakdown of any costs related to overheads. Do not include overhead costs as a % of the total budget. * If partial funding of a program is requested, please provide the full program budget, along with the amount requested from GSK. |

**Below you will find an example. Please amend the budget categories and space needed, if necessary. Complete the line items accordingly and provide as much detail as possible.**

**If preferred, a separate budget document may be attached to the request and the below may be left blank.**

**If you have any questions regarding budget estimates, please contact our inbox at** [ca.medical-education@gsk.com](mailto:ca.medical-education@gsk.com) **with your enquiries or to set up a conference call at your convenience.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Budget item | | Hourly cost | | Hours | Total | | Further description of expense if necessary |
| Logistics (e.g., venue) | | | | | | | |
|  | | $ | |  | $ | |  |
|  | | $ | |  | $ | |  |
| Audience generating material and activities (e.g., invitations, leaflets, electronic distribution) | | | | | | | |
|  | | $ | |  | $ | |  |
|  | | $ | |  | $ | |  |
| Faculty expenses (e.g., honoraria, travel, accommodation). For honoraria, please state the number of hours of work *and* hourly cost. Prep work can be included. | | | | | | | |
|  | | $ | |  | $ | |  |
|  | | $ | |  | $ | |  |
| Program material development (e.g., content development & delivery costs for webcasts, e-learning modules, slides, publications) | | | | | | | |
|  | | $ | |  | $ | |  |
|  | | $ | |  | $ | |  |
| Accreditation fees | | | | | | | |
|  | | $ | |  | $ | |  |
|  | | $ | |  | $ | |  |
| Other | | | | | | | |
|  | | $ | |  | $ | |  |
|  | | $ | |  | $ | |  |
|  | | $ | |  | $ | |  |
| **Full Program Total** | | | | | **$** | | |
| **Amount requested from GSK** (please provide if different from above and partial funding is requested). | | | | | **$** | | |
| **Are there multiple sponsors for this educational initiative?**  *Please note that this information is for our internal records and processes and does not impact the funding decision.* | | | | | | | Yes  No |
| **Do you require GSK to pay taxes on the funded amount? If yes, state province, applicable tax(es), and tax registration number(s):**  *GSK requires organizations to provide an invoice if tax payments are required.* | | | | | | | Yes  No |
| **Province** |  | | | | | | |
| **Tax** |  | | **Tax Registration Number** | | |  | |
| **Tax** |  | | **Tax Registration Number** | | |  | |

1. Declarations and Signature

|  |  |
| --- | --- |
| **Conflict of Interest Declaration** | |
| 1. To the best of your knowledge, do any individuals in your organization (e.g., executives, employees, volunteers, etc.) or family members of individuals in your organization have a direct conflict of interest with GSK (e.g., family relationship with a GSK employee, significant financial investment in GSK, business relationship with GSK, etc.)? | |
| Organization/Executives/Employees  Yes  *If yes, please explain:*  No | Family of Employees/Volunteers/Executives  Yes  *If yes, please explain:*  No |
| 1. To the best of your knowledge, do any individuals in your organization (e.g., executives, employees, volunteers, etc.) or family members of individuals in your organization have a role which involves making decisions or advising on or influencing decisions, on the regulation of medicines or vaccines, or the funding or provisions of healthcare, which could be a conflict? | |
| Organization/Executives/Employees  Yes  *If yes, please explain:*  No | Family of Employees/Volunteers/Executives  Yes  *If yes, please explain:*  No |
| 1. To the best of your knowledge, does this contribution, coupled with any other contributions from all GSK sources, in the current year exceed 25% of the total annual funding anticipated by your organization? | |
| Yes  *If yes, please explain:*  No | |
| 1. GSK is committed to meeting the highest ethical standards in the way we do business, including in how we partner with your organization. We will not make, offer to make, or authorize any payment or transfer of value to secure an improper advantage or to improperly obtain or retain business (e.g., to a sales agent, distributor or intermediary). Can you certify that your organization understands the importance of this commitment to GSK and that your organization will operate and represent our interests in line with these ethical standards? | |
| Yes  No  *If no, please explain:* | |

I certify that I am a duly authorized representative or agent of the application organization and that, to the best of my knowledge, the information provided is accurate. I understand that I may be required to provide additional documentation in support of the information provided above at the request of GSK and agree.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Signature |  | |
| Position/Title |  | Date |  | |
| If the funding application is successful, I agree to provide an executive summary of the education provided and the outcomes it achieved and for GSK Canada to have the right to post this summary on the GSK Canada independent medical education website for the purposes of transparency and to share best practice. | | | |

*Please note that payment details will be requested upon awarding of an educational grant. Payment must be made to an organization and not an individual’s account.*