Bristol-Myers Squibb Preview Form

This is an example of the application questions with which you will be presented. It is recommended that you compose the answers to the paragraph questions in a word processing program and then cut and paste that text into the online application.

Contact Information

Please add/select from below any additional people who should receive the correspondence for this grant. To create a new contact, click "Create New"

*First Name
(Text)(40 character maximum)
Instructions:

*Last Name
(Text)(40 character maximum)
Instructions:

Telephone
(Text)(30 character maximum)
Instructions:

*E-mail Address
(Text)(100 character maximum)
Instructions:

Requesting Organization

*Legal Name
(Text)(255 character maximum)
Instructions:

Address
(Text)(100 character maximum)
Instructions:

City
(Text)(50 character maximum)
Instructions:

State
(Single-Select List)
Instructions:

Zip
(Text)(20 character maximum)
Instructions:
Country
(Single-Select List)

Instructions:

*Requesting Organization Confirmation
(Checkbox List)

I certify

Instructions:

For an accredited grant, please confirm that the requesting organization is the accrediting as well as the payee organization.

For a non-accredited program, please confirm that the requesting organization is the payee organization.

Organization Details

Program Accredited?
(Yes/No)

Instructions:

Is requesting organization the accrediting organization?
(Yes/No)

Instructions:

Accrediting Organization

Accrediting Organization Legal Name:
(No input required)

Instructions:

Accrediting Organization Address:
(No input required)

Instructions:

Accrediting Organization City:
(No input required)

Instructions:

Accrediting Organization State:
(No input required)

Instructions:

Accrediting Organization Zip:
(No input required)

Instructions:
Accrediting Organization Country: (No input required)  

Accrediting Organization Contact Name (Text)(500 character maximum)  

Accrediting Organization Contact Email (Text)(500 character maximum)  

Accrediting Organization Contact Phone (Text)(500 character maximum)  

Instructions: For Example, 888-888-8888  

Payee Organization Address (Paragraph)(2000 character maximum)  

Instructions: If the address for the payee differs from the information listed above, please provide the information below.  

Payee Organization Address (non-accredited) (Paragraph)(2000 character maximum)  

Instructions: If the address for the payee (requesting organization) differs from the information listed in the "Requesting Organization" section, please provide the information below.  

*Is there a partner organization for this request? (Yes/No)  

Instructions:  

**Partner Organization**  

Partner Organization Name (Text)(500 character maximum)  

Partner Organization Address (Text)(500 character maximum)  

Partner Organization City (Text)(500 character maximum)  

Partner Organization State (Single-Select List)  

Instructions:
Partner Organization Zip
(Text)(15 character maximum) Instructions:

Partner Organization Country
(Single-Select List) Instructions:

Partner Contact Name
(Text)(500 character maximum) Instructions:

Partner Contact Email
(Text)(500 character maximum) Instructions:

Partner Contact Phone
(Text)(500 character maximum) Instructions:
For example, 888-888-8888

*Grantseeker Organization
(Single-Select List) Instructions:
Which organization are you employed by?

Grantseeker Employer

Grantseeker Employer Name
(Text)(500 character maximum) Instructions:

Grantseeker Employer Address
(Text)(500 character maximum) Instructions:

Grantseeker Employer City
(Text)(500 character maximum) Instructions:

Grantseeker Employer State
(Single-Select List)

Grantseeker Employer Zip
(Number)(15 character maximum) Instructions:

Grantseeker Employer Country
(Single-Select List) Instructions:
Project Details

* RFP Code
(Single-Select List)
Instructions:
Select the RFP code for the grant application

* IME Therapeutic/Disease Area(s) addressed
(Single-Select List)
Instructions:

Oncology Disease State
(Multi-Select List)
Instructions:

Cardiovascular Disease State
(Multi-Select List)
Instructions:

Immunoscience Disease State
(Multi-Select List)
Instructions:

Virology Disease State
(Multi-Select List)
Instructions:

* Project Title
(Text)(255 character maximum)
Instructions:

Program Start Date
(Date)
Instructions:

Program End Date
(Date)
Instructions:

* Is the program accredited?
(Yes/No)
Instructions:

Select the primary accrediting agency
(Single-Select List)
Instructions:

Accrediting Body
(Text)(500 character maximum)
Instructions:
Name of the Accrediting body if you selected "Other" to the previous question
Primary Accreditation Expiration Date
(Date)

Select any secondary accrediting agencies
(Multi-Select List)

*Geographical Area of Program
(Single-Select List)

*Learning Objectives
(Paragraph)(2000 character maximum)

*Describe your educational outcomes strategy. Specify any follow up plan with the program participants
(Paragraph)(2000 character maximum)

*Enter the highest Moore's level of Outcomes you plan to achieve with this educational grant
(Single-Select List)

*If this application is accepted, would BMS be the sole supporter of this program?
(Yes/No)

How many other supporters are expected?
(Number)(15 character maximum)

*Target Audience
(Multi-Select List)

*Please indicate whether there is any opportunity to exhibit at the event
(Yes/No)

Please provide the contact for exhibit offerings
(Paragraph)(2000 character maximum)

*Please indicate whether there is any opportunity
for complimentary attendance at the event for observation and evaluation (Yes/No)

Please indicate the number of registrations (Number)(15 character maximum) Instructions:

*Is your organization submitting requests for additional funding to other BMS departments/countries associated with this grant request? (Yes/No) Instructions:

Which BMS department/countries, please explain (Paragraph)(2000 character maximum) Instructions:

Activity Details

Modality Types (Multi-Select List) Instructions:

What types of modalities will be involved with this program? (Hold "CTRL" to select multiple modalities)

*Number of modalities associated with this request? (Single-Select List) Instructions:

This number should match the count of modalities that are selected in the question above
Modality Metric Table
(No input required)

Instructions:
For Modality, please use the following codes:

<table>
<thead>
<tr>
<th>Modality Type</th>
<th>Modality Code</th>
<th>Modality Type</th>
<th>Modality Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enduring: Electronic Media</td>
<td>1</td>
<td>Live In-person: Multiple Location series</td>
<td>6</td>
</tr>
<tr>
<td>Enduring: Print</td>
<td>2</td>
<td>Live In-person: Satellite Symposium</td>
<td>7</td>
</tr>
<tr>
<td>Internet</td>
<td>3</td>
<td>Live Remote: Satellite Broadcast</td>
<td>8</td>
</tr>
<tr>
<td>Live In-person: Conference</td>
<td>4</td>
<td>Live Remote: Teleconference</td>
<td>9</td>
</tr>
<tr>
<td>Live In-person: Institutional</td>
<td>5</td>
<td>Live Remote: Webcast</td>
<td>10</td>
</tr>
</tbody>
</table>

Modality Metric 1
Instructions:

Modality Metric 2
Instructions:

Modality Metric 3
Instructions:

Modality Metric 4
Instructions:

Modality Metric 5
Instructions:

Modality Metric 6
Instructions:

Modality Metric 7
Instructions:

Modality Metric 8
Instructions:

Modality Metric 9
Instructions:

Modality Metric 10
Instructions:

Multiple Program Locations
(File Upload) File Upload; 10485760 byte limit
If your activity/activities will take place at multiple locations, please download the multi-location template by clicking here. Please complete and upload the form.
Project Budget

*Program Budget
(File Upload)

Instructions:
Please upload the Program Budget spreadsheet (xls, xlsx format only)

*Amount you are requesting from BMS (in dollars)
(Currency)(20 character maximum)

Instructions:

*If multi-supported, other supporter funding expected
(Currency)(15 character maximum)

Instructions:

Attachments

*Full Proposal
(File Upload)File Upload; 524288 byte limit

Instructions:
Please attach the full grant proposal including agenda, needs assessment, learning objectives, outcomes etc. (in pdf format only)

Other Proposal Attachment
(File Upload)File Upload; 524288 byte limit

Instructions:
Other supporting documents (in pdf format only)

Certification

I am fully authorized to submit this request on behalf of the requesting organization and any partner organization, and I affirm that all responses and information provided in response to this application are truthful, accurate and complete.

I understand that Bristol-Myers Squibb reserves the right to disclose, at its sole discretion and in whatever matter it deems appropriate, any and all information in its possession regarding this request. Bristol-Myers Squibb shall have no obligation to notify or seek the consent or approval of a requestor or any partner(s) in connection with any such disclosure.

I represent that this request for funding is submitted solely in response to a request for proposal posted on the BMS Independent Medical Education website, and was not prompted by a direct or indirect solicitation from any employee of the Bristol-Myers Squibb Company ("BMS") or any consultant or vendor of BMS.

I represent and warrant that the organization on whose behalf I am submitting this application has not
taken and shall not take any action nor make any payment in violation of the Foreign Corrupt Practices Act of 1977, as amended, or any comparable laws in any country (collectively, the "FCPA"). I represent and warrant that no person employed by the organization on whose behalf I am submitting this application or the organization's agent(s) is an official of the government of any country or of any agency thereof, and that no part of the Funding shall accrue for the benefit of any such official. For purposes of reasonably ensuring compliance with the FCPA, the organization on whose behalf I am submitting this application shall make available for audit by BMS or its agents, representatives and regulators, upon BMS' reasonable request, books, records and other documentation relevant to ensuring compliance with this provision.

I agree that the requesting organization and any partner organization(s) will comply with Section 6002 of the Affordable Care Act, which added Section 1128G to the Social Security Act, and its implementing regulations codified at 42 CFR 402 & 403 (Collectively the "Sunshine Act").

If all or any portion of the Funding is used to compensate, or is otherwise provided, as a fee or reimbursable expense(s), to a "Covered Recipient" as defined in the Sunshine Act (including without limitation licensed, practicing or non practicing physicians and teaching hospitals), I, on behalf of the requesting organization, represent and warrant that

• Special rules for payments or other transfers of value related to accredited/certified or non-accredited/non-certified continuing education program(s) will be followed as defined in 42 CFR Section 403.904(g); and
• Each Covered Recipient shall agree in writing that BMS may disclose, for any lawful purpose, within its sole discretion, the total compensation (fees and reimbursable expenses) provided to the Covered Recipient; and
• My organization shall certify in writing to BMS within 30 days of making any such payment, all amounts actually paid to the Covered Recipient (for any purpose) from the Funding, in the form and/or manner as reasonably requested by BMS; and
• My organization will indemnify BMS for any government related fine or penalty for non-compliance with the Sunshine Act that results from my organization’s failure to comply with these obligations.

I acknowledge that grants made by BMS must not in any way be connected to, or conditioned upon, any prescribing, purchasing, or recommending any product manufactured or marketed by BMS.

I also understand that BMS only makes educational grants for legitimate educational, health-related or scientific purposes, and that such funds may only be used to support independent, fair, and balanced programs and activities.

I affirm that this request will be for a program that has not occurred and for which the content has not been developed.

I acknowledge that submission of a request for an educational grant does not mean that the request will be funded by BMS, and that only a BMS grant review committee can approve funding of such requests.

I understand that BMS cannot and will not commit to process any request within a specific period of time except for those posted on the Independent Medical Education website. I understand that in certain
instances where BMS decides to make a grant, the company may choose to award that grant in installments.

I understand that BMS will provide support for programs where employees of the provider/partner are paid honoraria for speaking or presenting, only if they are speaking in an educational capacity which represents an additional activity above and beyond the expectations of their professional affiliation or current responsibilities.

I have read and agree to the BMS IME Terms and Conditions, Click here to read the Terms and Conditions on the BMS Grants Website

*AS A CONDITION TO THE SUBMISSION OF YOUR REQUEST, PLEASE READ AND INDICATE AGREEMENT BY CERTIFYING THE ABOVE STATEMENT.

Instructions:

I Certify