



Program Submission Form for

**2014 Mid America College Health Association Annual Meeting**  
**November 5-7, 2014 | Illinois State University | Normal, IL**

To submit a proposal:

1. Complete the **Program\*\* Information Form** below.
2. For each co-presenter, complete a separate **Co-Presenter Information Form**.
3. Email completed forms to [Wellness@IllinoisState.edu](mailto:Wellness@IllinoisState.edu).

\*\*All programs must be 60 minutes in length.

Required fields are indicated by an asterisk (\*). If you have any questions or concerns, please contact Program Chair Nikki Brauer at [Wellness@IllinoisState.edu](mailto:Wellness@IllinoisState.edu).

**Program submission deadline is Friday, September 12, 2014.**

Topics of interest identified by MACHA members include, but are not limited to:

- Administration
- Best practices in college health
- Exemplars
- Healthy Campus 2020
- Leadership
- Marketing & Social Media
- Research
- Sexual Violence
- Student Success
- Women's Health

## Program Information

<p><b>*Program Title:</b></p> <p>The title of the proposed program should reflect the content of that program. While cute titles may sound clever, they tend to detract from the professionalism of the conference and make it harder to determine what will be presented.</p>													
<p><b>*Primary Presenter's Name:</b></p>													
<p><b>Co-Presenters:</b> For all co-presenters, please list names, degree(s), institution/employer, and email address.</p>													
<p><b>*Would you like your program to be considered for a poster display if not selected as a program?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<p><b>Does your program contain or report original research?</b> If yes, please specify in the abstract below.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<p><b>*Abstract:</b> Please provide a short (75 words) descriptive abstract of your presentation. Please be concise and clear with your description. MACHA reserves the right to edit.</p>													
<p><b>List any evidence-based references used to develop this presentation.</b> Please cite specific data, journal articles, official standards, and/or recommendations, etc. (Not a prerequisite for program selection.)</p>													
<p><b>Does your program address diversity?</b> If so, describe how it addresses diversity based on the following aspects: age; gender identity, including transgender; marital status; physical size; psychological/physical/learning disability; race/ethnicity; religious, spiritual, or cultural identity; sex; sexual orientation; socioeconomic status; military veteran status. Not a prerequisite for program selection.</p>													
<p><b>*Audience:</b></p> <p>Who is the expected learner for your program? Note: the CE committee uses this information to determine CE credit for the program. Please check all that apply.</p>	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Administrator</td> <td><input type="checkbox"/> Pharmacist</td> </tr> <tr> <td><input type="checkbox"/> Advanced Practice Clinician</td> <td><input type="checkbox"/> Physician</td> </tr> <tr> <td><input type="checkbox"/> Counselor</td> <td><input type="checkbox"/> Psychologist</td> </tr> <tr> <td><input type="checkbox"/> Dietitian/nutritionist</td> <td><input type="checkbox"/> Social Worker</td> </tr> <tr> <td><input type="checkbox"/> Health Educator</td> <td><input type="checkbox"/> Student</td> </tr> <tr> <td><input type="checkbox"/> Nurse</td> <td><input type="checkbox"/> Other, please specify: _____</td> </tr> </table>	<input type="checkbox"/> Administrator	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Advanced Practice Clinician	<input type="checkbox"/> Physician	<input type="checkbox"/> Counselor	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Dietitian/nutritionist	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Health Educator	<input type="checkbox"/> Student	<input type="checkbox"/> Nurse	<input type="checkbox"/> Other, please specify: _____
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<p><b>Practice Gap:</b> Briefly describe what the audience needs to "know" or "know how to do" that will be addressed by this session. Specify the source(s) that support the existence of this gap* in knowledge or skills (data, standards, or other evidence-based support, personal experience, etc.). Please also address the current state and what could be accomplished in this area.</p> <p><i>*When there is a gap between what the professional is currently doing or accomplishing compared to what is desired/achievable on the basis of current professional knowledge, there is a professional practice gap.</i></p>													
<p><b>* Type of Gap:</b> Based on the description above, this presentation will address a gap in:</p>	<input type="checkbox"/> Knowledge <input type="checkbox"/> Skill <input type="checkbox"/> Both												

## Learning Objectives and Content

**Important:** Refer to the [Instructions for Writing Learning Objectives and Content](#) before completing this section.

Each **Learning Objective** should complete the phrase, "The participant should be able to..."

Begin each objective with **one** of the following **measurable verbs**: Describe, Recite, Explain, Identify, Discuss, Compare, Contrast, Define, Differentiate, List, Outline, Review.

Make a separate objective for each action. Example: *Define sleep deprivation and the consequences*. These are **two separate actions** and should be **split into two objectives** as follows:

1. *Define sleep deprivation.*
2. *List the consequences of sleep deprivation.*

**Content** is the information needed to meet each learning objective.

**Objective:** *Define sleep deprivation.*

**Content:** *degrees of sleep, quantity of sleep, quality of sleep, circadian factors*

**Note:** If the presentation will address mental health issues, please ensure this is reflected in the objectives.

* <b>Learning Objective #1:</b>	
* <b>Content for Objective #1:</b>	
* <b>Learning Objective #2:</b>	
* <b>Content for Objective #2:</b>	
<b>Learning Objective #3:</b>	
<b>Content for Objective #3:</b>	
<b>Learning Objective #4:</b>	
<b>Content for Objective #4:</b>	

## Primary Presenter Information

The primary presenter is the main contact person for this proposal. It is the primary presenter's responsibility to ensure that the information submitted for the program and for all co-presenters is complete and accurate.

Presenter Information is required for each presenter, co-presenter, panel member, discussion leader, etc. If a presenter is speaking more than once, this information must be submitted for each program.

<b>* First Name:</b>	
<b>* Last Name:</b>	
<b>Degree(s)</b> as you would list them following your name i.e., MPH, BSN:	
<b>Job Title:</b>	
<b>* Institution/Employer:</b>	
<b>* Address 1:</b>	
<b>Address 2:</b>	
<b>* City:</b>	
<b>* State:</b>	
<b>* Zip:</b>	
<b>Telephone:</b>	
<b>* Email:</b>	
<b>*Describe your training or experience that establishes your <u>expertise on the proposed topic.</u></b>	
<b>*I intend to register for the MACHA 2014 Meeting as a:</b>	<input type="checkbox"/> Regular Attendee <input type="checkbox"/> Student Attendee

## Primary Presenter Faculty Disclosure Form

All faculty/presenters/authors are required to disclose any and all potential conflict(s) of interest for themselves and/or their spouse/partner (owner or sole proprietor, speakers' bureau, grant/research support, major stock shareholder, employee/paid consultant, etc.). All disclosures that are determined by the Program Coordinator to be relevant relationships will be shared with the participants/learners in meeting materials and prior to the start of an educational activity.

**Name:**

**Program Title:**

**\* Do you and/or your spouse/partner have a financial interest, arrangement, or affiliation with any organization or business entity (including self-employment and sole proprietorship) that could be perceived as a conflict of interest or a source of bias in the context of this presentation?**

*Relationships must be disclosed during the time when the relationship is in effect and for 12 months afterward.*

Yes (myself)     Yes (spouse/partner)

No

If yes, enter the name of the organization or business entity next to the type of affiliation below.

Recipient of honoraria, reimbursement for expenses, or other financial assistance for this program \_\_\_\_\_

Owner/Sole Proprietor \_\_\_\_\_

Employee/Consultant \_\_\_\_\_

Grant/Research Support \_\_\_\_\_

Speaker's Bureau \_\_\_\_\_

Major Stock Shareholder \_\_\_\_\_

Royalties \_\_\_\_\_

Other Financial or Material Support \_\_\_\_\_

*By typing my name below, I am providing it to represent my electronic signature approving all the information entered in this Call for Programs Form. I further attest that all submitted information is accurate. I have identified all potential conflicts of interest and for those conflicts of interest that could bias my presentation, I agree to abide by the resolution of conflict as determined by the Program Coordinator.*

**\*Signature:**

**\*Date:**