ONLINE CONTINUING MEDICAL EDUCATION (CME) PROGRAM PRESENTER AGREEMENT

Curriculum: [*Title of Talk and description of Curriculum*]. The Effective Date of this Agreement is [date or presentation].

Presenter: [Name]

On behalf of Boston Children's Hospital (BCH) and its Continuing Medical Education (CME) Department, we are pleased to engage you to provide and perform the Curriculum identified above as a Presenter as further described below. The terms of your engagement hereunder are as follows and by signing below you agree to the following:

1. I acknowledge that I have read the "Guidelines-Boston Children's Hospital Online Continuing Medical Education (CME) Program".

2. I agree to present the Continuing Medical Education Curriculum on [*date*] at [*time*].

3. I approve that this presentation may be filmed and available for live external viewing by the public and hereby release the use of my name, image, likeness, still or motion picture and/or audio recording made therefrom for the purposes set forth herein.

4. The Curriculum is my own original material or material for which I have full authority to grant the rights set forth in this Program Presenter Release.

5. My assignment hereunder is granted based on BCH assurance that the Curriculum will be used for research, teaching and educational purposes only and to provide Continuing Medical Education services with or without charging a fee, and that access to the materials will be as set forth in the Guidelines-Boston Children's Hospital Online Continuing Medical Education (CME) Program for CME enrollees unless otherwise agreed to by the Presenter. Intellectual property and copyrights in and to the Curriculum are owned by Boston Children's Hospital however, as a Presenter, I still retain my rights in the Curriculum for my academic research, teaching, and educational purposes but without the right to offer to any other party that will offer, display, reproduce and/or copy such Curriculum for CME purposes for a fee. By signing this form, I agree to any such reproduction as described herein and agree to remove any unauthorized patient Protected Health Information and/or I will provide patient permission approval, as necessary.

[*Faculty name, date, and electronic signature*

[Medical Director signature block]