CONTINUING MEDICAL EDUCATION

ACTIVITY PLANNING/REQUEST FORM

(CME Program)

REQUESTING PERSON/COMMITTEE/DEPARTMENT:_____

DATE:___ TIME:_____ PLACE:_____**CREDIT__HRS.**

TITLE:_____

ACTIVITY NEED: _____

ACTIVITY OBJECTIVES: (during the activity, the audience will):

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SPEAKER: _____**Speakers Bureau:**_____
PHONE #:_____ **SSN OR TAX ID #:** _____**Speakers Bureau tel.#:** _____

ACADEMIC TITLE:_____
_____

ADDRESS:_____

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ACTIVITY FORMAT: (x) Didactic (x) Q & A Period ( ) Panel
( ) Workshop ( ) Case Presentation
( ) Other _____

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EVALUATION: (x) Standard Form ( ) Test( ) QA Study
( ) Other_____

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DRUG CO. SUPPORT: ___Yes ___ No Amount to be paid if no support:_____

Company Name:_____ Confirmed? _____ Yes _____ No

Rep. Name:_____ Phone #:_____

Address: _____