Institute for Healthcare Communication

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CME/CE Workshop Cover Sheet

WORKSHOP INFORMATION

Organization Name: ______________________________

Organization Contact: ______________________________

Telephone: ______________ E-mail: ______________________________

Workshop: ______________________________

Other workshop/hours not listed: ______________________________

If different workshop duration please attach agenda

Workshop Date: ______________ Time: ______________ Number of participants: ________

Workshop Venue: ______________________________

Address: ______________________________

Town/City: ______________ State/Province: ________ Zip/Postal Code: ________

Trainer(s): Trainer 1: ______________ Trainer 2: ______________

Trainer 3: ______________ Trainer 4: ______________

ATTESTATION OF DISCLOSURE TO LEARNERS

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☐ **Trainer(s) attest to showing disclosure slide to all attendees prior to the start of workshop**

INSTRUCTIONS FOR CME/CE CERTIFICATES

☐ E-mail certificates directly to participants ☐ No certificates required ☐ No CME required

☐ E-mail all certificates to: ______________________________

☐ In addition to the Trainer(s), E-mail evaluation reports to: ______________________________

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Comments:

SUBMIT FORM

FOLLOWING THE WORKSHOP PLEASE SEND THIS COMPLETED FORM TO:

Mary Barrett

mbarrett@healthcarecomm.org

Fax: (800) 800-5907

Please include sign-in sheet, agenda, etc. if available (not required)

IF PAPER COPIES OF PARTICIPANT AND ASSESSMENT FORMS WERE USED PLEASE SCAN AND E-MAIL OR MAIL TO:

Mary Barrett
17 Robertson Drive
Bethany, CT 06524-3207
Tel: (800) 800-5907 x701