Institute for Healthcare Communication
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: _____

Location: ☐ Virtual ☐ In Person (if in person please indicate location below)

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: _____

_____

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