

Verification of Participation

VCU Health Continuing Medical Education



Please complete the form below if text attendance is not available. All fields are required to be completed for credit to be recorded.

Today's Date:	Program Name:		
Last Name:	First Name:	Middle Initial:	Degree(s):
Mailing Address:		Email Address:	
Work Phone:		Cell Phone:	
Specialty:		Employer/Institution/Organization:	
Number of Credits: <i>Indicate the number of credits you are claiming, based on the number of hours you participated in the activity.</i> Please reference the program materials for the number of credits available for this activity.		Credit type: <input type="checkbox"/> AMA PRA Category 1 Credit™ <input type="checkbox"/> Non-physician attendance	

I attest that I have participated in the above activity and am claiming credit commensurate with participation.

Signature