CMU CENTRAL MICHIGAN UNIVERSITY | College of Medicine

Office of Continuing Medical Education 2019

PHYSICIAN TEACHING CREDIT CLAIMED

For calendar year 2019, please enter the number of hours each month that you spent teaching residents and or medical students from CMU College of Medicine / CMU Partners accredited medical educational programs.

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Residents													
Students													

I attest to the accuracy of the information provided above and will claim the Category 2-A credit for teaching allowable for the period.

_____ _____ _____

Name Printed Signature Date

_____ _____ _____

Address City, St Zip E-Mail

☐ Accredited Medical Student Program ☐ OB/GYN Residency Program ☐ Family Medicine Residency Program ☐ Psychiatry Residency Program

☐ Emergency Medicine Residency Program ☐ Internal Medicine Residency Program ☐ Surgery Residency Program ☐ Other: _____

Please send the completed form to: e-mail – CMEDCME@cmich.edu Fax: 989.746.7579

PROGRAM DIRECTOR ATTESTATION

I agree that the physician above participated in resident and or medical student teaching for the periods identified above.

_____ _____ _____

Residency Program Director Name Printed (if applicable) Signature Date

_____ _____ _____

Medical Student Director Name Printed (if applicable) Signature Date