

CERTIFICATE OF PARTICIPATION

This certifies that:

(Name of Physician Participant)

has participated in the educational activity entitled:

(Title of CME Activity)

provided by: _____

(Name of CME Provider)

(Date of Activity)

(City/State of Activity)

and is awarded up to _____ credits.

This [activity type] activity, [activity title], with a beginning date of [activity dates] has been reviewed and is acceptable for up to _____ (Prescribed /Elective) credit(s) by the American Academy of Family Physicians. Physicians should only claim the credit commensurate with the extent of their participation in the activity.

I participated in _____ credits of this CME activity.

Physician Participant's Signature

Date

Signature of CME Activity Director

Date