CMU CENTRAL MICHIGAN UNIVERSITY | College of Medicine

Office of Continuing Medical Education **2021**

PHYSICIAN TEACHING CREDIT CLAIMED

For calendar year 2021, 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