COLLEGE OF MEDICINE
CENTRAL MICHIGAN UNIVERSITY

ACCME ACCREDITED WITH COMMENDATION

Continuing Medical Education

Exhibitor Application

EDUCATIONAL ACTIVITY INFORMATION

Activity Title:

Location of activity:

Date(s) of activity: Time:

Contact Person (Name & Title):

Organization: Department:

Address:

Phone: Fax:

Email:

Signature:

EXHIBITOR INFORMATION

Representative(s):

Company Name:

Product:

Address:

City, State, Zip code:

Phone: Fax (if applicable):

Email:

Payable to: Amount Paid:

Your signature below attests to the accuracy of the information you have provided above. If, at any time, your information changes, please inform the Office of Continuing Medical Education immediately and resubmit a new form. All Exhibitors must comply with the Accreditation Council for Continuing Medical Education (ACCME) ***Standards for Integrity and Independence in Accredited Continuing Education* (2020)**. https://accme.org/standards-resources

Signature: Date: