



**PHYSICIAN TEACHING CREDIT CLAIMED**

For calendar year 2023, 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 *AMA PRA Category 2 Credit™* for teaching allowable for the period.

Name Printed	Signature	Date
Address	City, St Zip	E-Mail

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> LCME Accredited Medical Student Program | <input type="checkbox"/> OB/GYN Residency Program            | <input type="checkbox"/> Family Medicine Residency Program | <input type="checkbox"/> Psychiatry Residency Program |
| <input type="checkbox"/> Emergency Medicine Residency Program    | <input type="checkbox"/> Internal Medicine Residency Program | <input type="checkbox"/> Surgery Residency Program         | <input type="checkbox"/> Pediatric Residency Program  |

Please send the completed form to: e-mail – [CMEDCME@cmich.edu](mailto:CMEDCME@cmich.edu)

**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