MAINE MEDICAL EDUCATION TRUST

CME DOCUMENTATION

## (Name of Joint Provider)

***(Date)***

### (Title of Program)

Please complete the following form **for your records** and make sure that you have **signed the registration form** (to provide proof of attendance) and **submitted your evaluation form** (for objectives meet/needs assessment data). We appreciate your cooperation with paperwork needed for CME approval.

*The Maine Medical Education Trust designates this live activity for a maximum of \_\_\_ AMA PRA Category 1 Credit(s)TM. Physicians should only claim credit commensurate with the extent of their participation in the activity.*

The Maine Medical Education Trust is accredited by the Maine Medical Association’s Committee on Continuing Medical Education and Accreditation to provide Continuing Medical Education (CME) to physicians**.**

* **I attended the entire program (\_\_\_\_\_\_ credits)**
* **I claim only \_\_\_\_ CME credits for this activity. (1 credit/hour - only claim actual time in this activity).**

Please print:

(The information below is used if this form is lost, returned or to update a CME database at your office or hospital)

Check one: MD \_\_\_\_\_\_\_\_ DO\_\_\_\_\_\_\_\_ Other (please specify)\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (certifies information is accurate)

If you have any questions regarding your CME documentation please email Elizabeth Ciccarelli, CME Coordinator for the Maine Medical Education Trust at [eciccarelli@mainemed.com](mailto:eciccarelli@mainemed.com). Thank you!