# PHYSICIAN SIGN IN

# **(TITLE OF ACTIVITY)**

(Date of Activity)

(Venue and City/State where Activity is held)

The following speakers disclose they have nothing to disclose: ­­­­­­­­­­­­­­­­­­­(Insert speaker name(s) who list no disclosures)

The following speakers disclose: (Insert speaker name(s) with each disclosed financial relationship and compensation type)

The following meeting planners disclose they have nothing to disclose: (Insert meeting planner and CME committee member name(s) who list no disclosures)

The following meeting planners disclose: (Insert meeting planner and CME committee member name(s) with each disclosed financial relationship and compensation type)

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of (name of the accredited provider) and (name of non-accredited provider). The (name of the accredited provider) is accredited by the Kentucky Medical Association to provide continuing medical education for physicians.

The (name of the accredited provider) designates this (learning format) activity for a maximum of (# of credits) *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**NOTE: Legibility is necessary in order for you to receive your CME certificates.**

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| **NAME and EMAIL** (PLEASE PRINT) | SPECIALTY | COMPLETE ADDRESS |
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