

CME REQUEST

I, _____, AM REQUESTING

APPROVAL TO ATTEND THE FOLLOWING CME PROGRAM: _____

MY LEAVE DATE IS _____ AT _____ AM PM

MY RETURN DATE IS _____ AT _____ AM PM.

PLEASE BE CERTAIN DATES & TIMES ARE FILLED IN OR WE CANNOT HONOR THIS REQUEST.

PLEASE NOTE: THIS REQUEST MUST BE APPROVED BY THE RESIDENCY DIRECTOR PRIOR TO SUBMISSION TO THE DIRECTOR OF MEDICAL EDUCATION.

PLEASE ATTACH A COPY OF THE CME PROGRAM REGISTRATION OR BROCHURE YOU WISH TO ATTEND.

DATE OF REQUEST _____

RESIDENT'S SIGNATURE _____

DATE _____

APPROVAL:

RESIDENCY DIRECTOR

DATE APPROVED

DIRECTOR OF MEDICAL EDUCATION

DATE APPROVED