



Office of Continuing Medical Education

CME Certificate Release Form

Complete and fax to 202-476-4741

Name:

Address:

Date:

Tel Number:

Fax Number:

Names and dates of activities that CME
credits are requested.

I _____ request that the Children's National Medical Center, Office of Continuing Medical Education release the above listed certification(s) of Continuing Medical Education credit to me. I confirm that name above and the signature below are mine and that I will not use the information provided for uses other than licensure and to receive medical institution privileges. I release Children's National Medical Center, the Office of Medical Education, activity instructors, program staff, and any other agents employed or controlled by CNMC or any of its subsidiary organizations.

I also authorize a \$10 processing fee to be charged to the following credit card

Visa Mastercard

Card Number: _____

Expiration Date: _____

Signature

Date