Activity Title: _____
Activity Date: _____
Activity Location: _____

SAINT LOUIS UNIVERSITY

American Medical Association

Physician's Recognition Award Category 1 Certificate
For Physicians

Please **PRINT CLEARLY.** Complete this form and return copy to the Registration Desk with your evaluation form at the conclusion of the activity.

Last Name	First Name	Middle Initial	Credentials
Address			Date of Birth
City/State/Zip			Email (your certificate will be mailed to this address)

Saint Louis University School of Medicine designates this educational activity for a maximum of xxx *AMA PRA Category 1 Credits*™.
Physicians should claim credit commensurate with the extent of their participation in the activity.

Please record below the number of credits you claim:

Credits Available	Credits Claimed
xxx	

Please Note: In order to obtain credit, this form must be completed, signed, and submitted to the registration desk by the conclusion of the activity. No forms will be accepted after this date.

Participant Statement: I have attended this CME activity for the credits indicated above.

_____
Signature Date

Saint Louis University CME Office 314-977-7401
3839 Lindell Blvd, St. Louis, Missouri, USA 63108

Revised 8/2015