## 

### DEMOGRAPHIC INFORMATION

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| **Organization** | | | | |
| Organization Name: | | | | |
| Address: | | | | |
|  | | | | |
| Phone Number: | | Fax Number: | | |
|  | | | | |
| Type of Organization (Please indicate what classification most accurately describes your organization): | | | | |
|  | Communications Company | |  | Not For Profit Foundation (501c3) |
|  | Consortium/Alliance | |  | Physician Member Org., Non-Specialty |
|  | Education Company, Other | |  | Physician Member Org., Specialty Based |
|  | Education Company, Physician Owned/Operated | |  | Publishing Company |
|  | Government or Military | |  | School of Medicine |
|  | Health Care Delivery System | |  | Voluntary Health Association |
|  | Hospital | |  | Other: |
|  | Insurance Company/Managed Care | |  |  |
|  | | | | |
| The CME Program of the Organization (one check per line): | | | | |
|  | **does** receive Commercial Support | |  | does **not** receive Commercial Support |
|  | **does** participate in Joint Providership | |  | does **not** participate in Joint Providership |
|  | **does** produce Enduring Material | |  | does **not** produce Enduring Material |
|  | **does** produce Journal-Based CME | |  | does **not** produce Journal-Based CME |
|  | **does** produce Internet CME | |  | does **not** produce Internet CME |
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| **Chief Executive Officer** | |
| Name: | |
| Title: | |
| Address: | |
| Phone Number: | Fax Number: |
| E-Mail: | |
|  | |
|  | |
| **Individual Responsible for CME Unit and for the Material Contained within this Application** | |
| Name: | |
| Signature: | |
| Date: | |
| Title: | |
| Address: | |
| Phone Number: | Fax Number: |
| E-Mail: | |
|  | |
|  | |
| **Contact Person for Application/Survey** | |
| Check here  if the contact person is the same as individual responsible for CME unit. | |
| Name: | |
| Title: | |
| Address: | |
| Phone Number: | Fax Number: |
| E-Mail: | |
|  | |