

**OFFICE OF CONTINUING MEDICAL EDUCATION
CERTIFICATE REQUEST FORM**

Attendee Name _____

Address _____

City _____ State _____ Zip _____

Telephone # _____ Fax # _____

Last 4 digits of Social Security # _____

Person Requesting certificate _____ Date of request _____

Program Title _____
-required-

Program Date _____
-required- Certificates are NOT available prior to January 1, 2000

DUPLICATE CERTIFICATE \$20

PAYMENT – Check *: Visa: MasterCard: AMEX:

Verification Code: **VISA AND MASTERCARD ONLY - INCLUDE THE 3 DIGIT VERIFICATION CODE THAT IS PROVIDED IN THE SIGNATURE PANEL ON BACK OF CARD**

Card Number:

Exp: / **Signature:** _____

[PRINT] Cardholder's Name: _____

*Make check payable to: CONTINUING EDUCATION/UT SOUTHWESTERN

Complete and mail form to: **UT SOUTHWESTERN MEDICAL CENTER
OFFICE OF CONTINUING EDUCATION
5323 HARRY HINES BLVD
DALLAS, TX 75390-9059**

or Complete and fax form to : (214)648-4804

-OFFICE USE ONLY-

Program # _____ **Program Coordinator** _____

Hours of Credit _____ **Certificate Type** _____

Coordinator: Please verify hours are correct and attendee was present for this program and return form to certificate clerk.

Date _____

Comments: