

Children's Medical Center of Dallas, Parkland Health & Hospital System, UT Southwestern University Hospitals & Clinics (UTSW Affiliated Hospitals)

Continuing Education Attestation

PRACTITIONER NAME: _____

DEPARTMENT/SPECIALTY: _____

I attest that within the last twenty-four months, I have completed _____ hours of Continuing Education Credits, of which hours _____% pertained to the specialty in which I currently practice and hold privileges for at one or more of the following (please check appropriate entities):

- _____ Children's Medical Center of Dallas
- _____ Parkland Health & Hospital System
- _____ UT Southwestern University Hospital - St Paul
- _____ UT Southwestern University Hospital - Zale Lipshy

Continuing Medical Education Credit requirements in a two-year period for these hospitals are:

- Physicians: 48 hours, 50% of which must be Category 1, and 1 hour in Ethics/Professional Responsibility per year
- Dentists: 24 hours
- Podiatrist: 30 hours

Attestation:

I will be able to provide documentation of the above information upon request from any of the above referenced hospitals at which I hold privileges.

Signed

Date

Please note that a random audit of Continuing Education Credits will be performed. If you are selected, submission requirements and due dates will be sent to you in writing.