ACOFPCA 2016 Continuing Medical Education Attestation Form

ACOFP CA's 40th Annual Scientific Medical Seminar
August 4-7, 2016

Name: _____

Address: _____

City/State/Zip: _____

AOA #: _____

Email: _____

PLEASE PRINT CLEARLY

I certify that I attended _____ hours of continuing medical education at the above referenced program (33 hours maximum).

Of the number of hours attested to above, _____ hours were designated as qualifying for Pain. (9 hours maximum)

_____ _____
Signature Date

Submission Options
Email: techsupport@acofpca.org
Fax: (909) 992-3174
Mail: PO Box 485, Rancho Cucamonga, CA 91729