Verification of Participation
VCU Health Continuing Education

Please complete the form below if text attendance is not available. All fields are required to be completed for credit to be recorded.

Today's Date:	Program Name:		
Last Name:	First Name:	Middle Initial:	Degree(s):
Mailing Address:		Email Address:	
Work Phone:		Cell Phone:	
Specialty:		Employer/Institution/Organization:	
Number of Credits: *Indicate the number of credits you are claiming, based on the number of hours you participated in the activity.* Please reference the program materials for the number of credits available for this activity.		Credit type: _____ AAPA _____ ACPE _____ ***AMA PRA Category 1 Credit™*** _____ ANCC _____ APA _____ ASWB ACE _____ General Attendance	

I attest that I have participated in the above activity and am claiming credit commensurate with participation.

_____
Signature

VCU Health™