HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICES
STATEMENT OF CONTINUING MEDICAL EDUCATION

This form is only required for those applicants applying for hospital or clinic privileges. It is not required for health plan credentialing.

Each licensing board has specific requirements governing the amount of CME credits needed each year to maintain current licensure. Please list below the courses completed, and the location, date and the number of hours of CME credits you have obtained during the past two years. If necessary, use an additional sheet, or you may send us a copy of your own listing of courses completed.

Course Taken	Location	Date	Number of CME Hours

During the past two years, _____% of my continuing medical educational activities was related to the privileges requested. I hereby certify that within the past two years I have completed at least the minimum number of hours of continuing education credits required by the board through which I am licensed, and have participated in all performance improvement activities as specified by the hospital(s) at which I have privileges. If audited, I will be able to provide documentation of the seminars or courses attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the medical staff.

_____ _____

Provider Name (Printed) Medical Director's Name (Printed)

_____ _____

Signature Medical Director's Signature

_____ _____

Date (do not type) Date (do not type)