

**ORGANIZATIONAL DEMOGRAPHIC FORM**

***Application for Continuing Medical Education Accreditation***

**Contact Information**

Name of Organization:

CME Administrator:

Primary Contact:

Organization Address:

Phone:

Email:

Has any of the above information changed since your last accreditation? If yes, please describe:

**Accreditation Request**

Please indicate the purpose of this application:

We are currently accredited and are reapplying for Accreditation

We are not currently accredited and are seeking Initial Accreditation (provisional)

If accreditation is awarded, we plan on engaging in joint providership with non-accredited organizations

**Type of Organization**

This organization is a (check one)

Hospital Hospital/Health System  State or Regional Specialty Society

Insurance Company/Managed Care Org. Publishing/Education Company

Medical Practice  Other *describe*:

**Please list all facilities/organizations included under this accredited CME program (if more than a single entity/facility):**

**Approximate # number of medical staff or members within your organization**: