

**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**: