**Activity Title:** Enter Activity Name: Enter Presentation Name

**Medical Director and Coordinator Name:** Enter Name here

**Location of Activity:** Enter location here  **Activity Date:** Enter Date here

***To be Completed by the CME Coordinator***

The above CPD Event was audited by Enter Name of Auditor, CPD Department. This form will be submitted to the Florida Hospital CPD Committee and become part of the official CPD Committee Minutes.

***Observations or Progress Report***

[ ]  All CME procedures and mandates have been followed

[ ]  Conflict of Interest Disclosures were made appropriately

[ ]  Changes need to be made in the following areas:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activity Coordinator Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CPD Auditor Date

CPD Department

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Orlando, FL 32804

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