Participant Credit Documentation Form (PCD)

Please complete the following form and return at the conclusion of the conference. Please keep your certificate once you receive it, as there will be a $15.00 fee for requests for mailing duplicate certificates after the conference.

Program Title: GCAPP Fifth Annual Conference

Date: October 22, 2009

Please Print

Name:_________________________________ Last 4 digits SS#:________________________

Home Address: ____
Street City State Zip Code

Home Phone: ____________________ Certification/Degree: __________________________

Employer: ____

Email: _________________________________ Office Phone: _________________________

Office Mailing Address:____

Job Title: ____

Discipline: (Choose one: Allied Health, Dentistry, Health Careers, Medicine (MDs only),

Mental Health, Nursing, Pharmacy, Public Health, Other__________________________)

Specialty: ___________________________ (Ex. Counselor, Social Worker, Psychologists, etc.)

Greensboro AHEC will award 0.4 CEU (4 contact hours) to participants attending the entire program.

By my signature, I attest to my attendance for the above stated hours.

______________________________________ ________________________
Signature Date

1/28/04