MEDICARE RESIDENT, PRACTICING PHYSICIAN, AND OTHER HEALTH CARE PROFESSIONAL TRAINING PROGRAM

SIGN-IN SHEET

[Insert Name of Organization]
[Insert Date of Course]

NAME (Please print)	DEPARTMENT	TELEPHONE #	POSITION
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________

FACILITATORS: Please make copies of completed Sign-in Sheets for your locked, confidential file and mail original Sign-in Sheets to:

Ann Palmer
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-13-07
Baltimore, MD 21244