LECOM
Lake Erie College of Osteopathic Medicine
1858 West Grandview Blvd. Erie, Pennsylvania 16509
(814) 866-6641 www.lecom.edu

Clinical Rotation & Preceptor Continuing Medical Education

Dear Doctor,

Thank you for participating in the education of a LECOM medical student. By working with the student, you earn one (1) category 1-B continuing medical education credit for each hour of instruction. For example, if you work 160 hours with a student, we will submit 160 CME credits. We will submit all of your teaching hours to the AOA, however, the AOA will only use 20 hours per year to meet a physician's AOA CME requirement.

To receive these credits, please complete the information requested below , sign your name and return the form to the LECOM CME office. We submit credits to the AOA at the end of each calendar year quarter.

Your support of LECOM's educational goals and our students is greatly appreciated.

You may download this form at www.lecom.edu/cme. Requires Adobe Acrobat Reader.
Mail or fax completed form to: CME Coordinator
Lake Erie College of Osteopathic Medicine, 1858 W. Grandview Blvd., Erie, PA 16509
For questions call: (814) 860-5125 Fax: (814) 866-8408

Please print or type all information.

Physician _____

AOA No._____

Office Address _____

_____

City _____ State____ Zip _____

Student _____

Hours _____

Dates ____/____/_____ to ____/____/_____

If any other physicians in your office participated in the training of this student, please list physician's name, AOA Number and hours with student.

Physician _____

AOA No. _____ Hours _____

Physician _____

AOA No. _____ Hours _____

Physician _____

AOA No. _____ Hours _____

I certify that I have completed the above hours of clinical instruction.

Signature (Required)_____ Date ___/___/____

Please print or type all information.

Physician _____

AOA No._____

Office Address _____

_____

City _____ State____ Zip _____

Student _____

Hours _____

Dates ____/____/_____ to ____/____/_____

If any other physicians in your office participated in the training of this student, please list physician's name, AOA Number and hours with student.

Physician _____

AOA No. _____ Hours _____

Physician _____

AOA No. _____ Hours _____

Physician _____

AOA No. _____ Hours _____

I certify that I have completed the above hours of clinical instruction.

Signature (Required)_____ Date ___/___/____

Updated: 4/12