



CERTIFICATE OF ATTENDANCE CLAIM FORM

Please print legibly

TITLE: Medicaid Billing for Smoking Cessation, Advice, Scenarios, and Questions from the Field

February 21, 2012

Last Name First Name

Street Address *(where you wish certificate to be mailed to)*

City State Zip Code

Email

Please indicate the number of hours you attended EACH session, enter the TOTAL in the box (lower right) and submit this form before you leave.

Scheduled Hours	Maximum Credit Hours	Actual Hours of Attendance
12 noon – 1 pm	1.0	

Please return this completed form **(by February 28, 2012)** to receive credit for this program.
FAX to Glenn Pareira, III at 518-891-6159. Respondents information will be held confidential, to be forwarded only to the accrediting agency for CME/Continuing Education Credit. Thank you.