ST. JOHN'S UNIVERSITY
College of Pharmacy and Health Sciences

VERIFICATION OF CONTINUING EDUCATION PARTICIPATION

IMPORTANT: Each attendee wishing to receive CE credit must print all information requested below and return this form to the sponsor before leaving the meeting. This will assure prompt and accurate issuance of your continuing education credit.

NABP ID# ☐☐☐☐☐☐__ **Birthday** ☐☐ ☐☐

(not your license #; not your Social Security #) **Month** **Day** (*not the year)*

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐

(First) MI

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(Last)

Home Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐☐☐☐

City State Zip Code

Home Phone (_____) _____ **Business Phone** (_____) _____

States Licensed In: _____**E-mail**:_____

Pharmacy Practice (please check all that apply):

- ☐ **Community**
- ☐ **Hospital**
- ☐ **Other Institutional**
- ☐ **Industrial**
- ☐ **Managed Care**
- ☐ **Home Care**
- ☐ **Consulting**
- ☐ **Long Term**
- ☐ **Pharmacy Technician**
- ☐ **Other Health Care Professional**
- ☐ **SJU Preceptor**
- ☐ **SJU Faculty**
- ☐ **SJU Student**
- ☐ **SJU Alum**

Current Position ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Employer ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Program Date
You Attended _____

CE Contact Hours
You Earned Today_____

Please note: statements are no longer mailed to participants.
Credit will be posted to CPE Monitor within six weeks after the seminar.

*** I certify that the above information is correct:** _____

Participant's Signature

OFFICE USE:
PARTICIPATION # _____

Palliative Care in Stroke
September 14, 2017