Connecticut Society of Eye Physicians
P.O. Box 854, Litchfield, CT 06759
Email- debbieosborn36@yahoo.com fax- (860)567-3591

Request Form for copy of Physician's CME Certificate

Date of Meeting______________________________(can only request CME from last 12 months)

Name ______________________________________

Email Address________________________________

Date of Request_______________________________________(Please allow two weeks for verification)

Did you complete the Evaluation Form for this meeting and attach to request?   Yes___________