



PRE-APPLICATION FOR CME ACCREDITATION

Organization Name: _____

Contact Name: _____

Address: _____

Phone: _____ **Email:** _____

Brief Description of Organization Applying for Accreditation (i.e.: size, scope of physician practices, type of organization, etc.):

Description of the physician group(s) being targeted (i.e.: hospital and 10 mi. of rural surrounding area, specific physician group, etc.):

Description of the CME Committee: (i.e.: size, scope of physician practices, frequency of meetings, etc.):

Description or List of Previous Educational Activities Presented by Organization (i.e.: jointly-sponsored, Category II, etc.):

Estimated Number of Activities and Total Credit Hours Offered Per Year: _____

Expected Types of Activities to be Offered (i.e.: Grand Rounds, Conferences, etc.):

Estimated Date to Submit Self-Study: _____

*When completed please send with a \$35 check made payable to WSMA to:
Washington State Medical Association, Attn: Jodi Smith, 2033 6th Ave., Ste. 1100, Seattle, WA 98121*