UNIVERSITY OF NEW ENGLAND
College of Osteopathic Medicine
Department of Continuing Medical Education

PRESENTER CONTACT/BIO SHEET

PROGRAM NAME: _____
PROGRAM DATES: _____

CONTACT INFORMATION			
Speaker Name		**Credentials/Degrees**	
Phone(s)	*#1*	*#2*	*#3*
FAX			
Email address			
Preferred Mailing Address Street/Apt			
City, State, Zip			
#1 Presentation Title			
#2 Presentation Title			
***Social Security #**			

**SS # required for payment of honoraria and/or travel expense reimbursements (if applicable)*

BIOGRAPHICAL INFORMATION			
EMPLOYMENT HISTORY			
Current		*Title/position:*	**How long?**
Previous		*Title/position:*	**How long?**
EDUCATION			
Undergrad			**Year(s)**
Grad			**Year(s)**
Postgrad			**Year(s)**
Other			**Year(s)**
PHYSICIAN POSTGRAD			
Residency			

- OVER PLEASE -

Board Certifications	
Other	

OTHER RELEVANT BIO INFORMATION

SHORT DESCRIPTIONS (1 for each presentation)
Session #1 Title:
Session #2 Title:

GOALS AND LEARNING OBJECTIVES (1-2 for each presentation)

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