Indiana University School of Medicine -- Visiting Professor Program

CME Office Use Only:

ID No.__________________

REQUEST FOR SPEAKER

Hospital/Institution:

Address:

Contact Person:

Title: Email Address:

Phone Number: Fax Number:

Speaker Requested:

Topic:

Date: Alternate Dates:

Starting Time: Ending Time:

Room Location:

Location to meet contact person ½ hour prior to activity:

Prospective Audience Size:

Background of majority of audience members (specialty):

Please attach a map and parking information for your speaker.

REQUEST FOR FUNDING SUPPLEMENT

- ☐ Requesting Hospital will pay all costs of the event
- ☐ Requesting Hospital is applying for partial supplement from IUSM ($200-600)
- ☐ Requesting Hospital is applying for full supplement from IUSM (maximum $750)

If applying for full or partial financial supplement, please complete the information below:

Amount requested: __________ Requested by: ____

Fed. ID #: _________________ **Signature:** ____________________________ Date: ____________

(original signature required)

Check should be made payable to:

____

____

____

Send completed form to:
Indiana University School of Medicine
Division of Continuing Medical Education
Attn: Kim M. Denny
714 N. Senate Ave., EF 200
Indianapolis, IN 46202
(317) 274-4220 / Fax (317) 274-4638