



RHODE ISLAND ACADEMY OF
 FAMILY PHYSICIANS
 STRONG MEDICINE FOR RHODE ISLAND

CERTIFICATE OF PARTICIPATION

This certifies that:

_____ (Name of Physician Participant)

has participated in the educational activity entitled:

New England Chapter Regional Meeting of the American College of Sports Medicine

(Title of CME Activity)

provided by: American Academy of Family Physicians
 (Name of CME Provider)

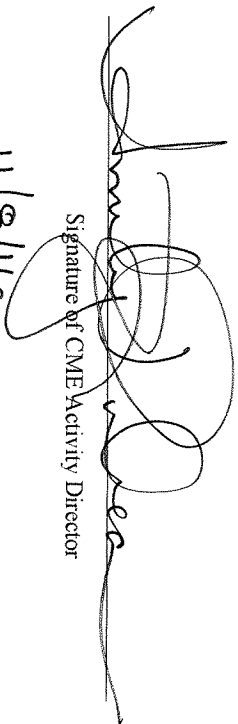
October 13 & 14, 2016 Providence, RI
 (Date of Activity) (City/State of Activity)

(Date of Activity) (City/State of Activity)

This activity has been reviewed and is acceptable for up to 9 (Prescribed /Elective) credit(s)
 by the American Academy of Family Physicians.

I participated in _____ credits of this CME activity.

Physician Participant's Signature _____ Date _____


 Signature of CME Activity Director

11/8/16
 Date