Arab Board For Health Specializations

Continuing Medical Education (CME)

Accreditation Application									
Provider Information									
Organization Name:									
Type of Organizing Institute:	☐ Health Professionals Societies ☐ Health Science /Medical Colleges of University ☐ Hospitals with Academic & training Department ☐ Health Institutions ☐ Specialized Organization for CME ☐ Private Hospital of Academic Standing ☐ Other (Specify)……								
Mailing Address:	P.O. Box:		City		Postal code:				
E-mail & Website:	E-mail		Website						
CME Leadership & Administrative Support of Organization									
CME Director:		Phone		fax					
E-mail									
Position in the Organization/Institution:									
CME Office Administrator's Name:									
Contacts:	Phone		Mobile		Fax				
Email:									
Mailing Address:	P.O. Box:		City		Postal code:				
Types of Activities to be Offered									
Specialty areas:	□ All Medical and Health Fields □ Specialty area: please specify_____								
Activity Type:	☐ Conference ☐ Symposium ☐ Seminar ☐ Course ☐ Lecture ☐ Series of Lectures ☐ Workshop ☐ Specialized Workshop ☐Other:								
Anticipated Activities Locations									
Sponsorship: *(Check only one)*	☐ Directly sponsored by: ☐ Jointly sponsored: (if any) ……..								
Target Audience									
Education Method	☐ Plenary lecture ☐ Didactic lecture /Q&A ☐ Free Communication ☐ Panel Discussion ☐ Demonstration ☐ Case Study ☐ Video/ interactive video ☐ Other (specify)								
Teaching Aids	☐ Power Point Presentations ☐ Video ☐ Tele Conference ☐ Slides ☐ Transparencies ☐ Manuscript ☐ Other (specify)								

For ABHS use only:

Date received:									CE's Officer Signature:

ABHS- CME Meeting: Date_____

Motion: ☐ Approve Accreditation ☐ Disapprove Accreditation: Justification_____

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_____ **ABHS Official Name/ Signature**

CME Provider Number									

Remarks: