



DP and JP Application Change Request

MedChi CME Department

Note: This Form is to only be used after an application has been approved

Date:

Type of CME provider: Direct Provider Joint Provider

Organization name:

Activity Name:

What part of the application needs to change: Step 1 Step 2 Step 3

Add additional documents/paperwork

Remove documents/paperwork

Describe what needs to be done:

Authorized Representative Printed Name:

Authorized Signature:

Date: