



**Nicklaus  
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Session Title(s) \_\_\_\_\_

\_\_\_\_\_

Date of presentation: \_\_\_\_\_

\_\_\_\_\_  
Print Name

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Signature

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This form is to be returned to the CME office upon receipt. You may fax this form to (305) 669-6531 or scan and e-mail the signed form to [cme@Nicklaushealth.org](mailto:cme@Nicklaushealth.org). Please keep a copy for your records.

Thank you for your cooperation!