**Educational Objectives**

At the conclusion of this activity, the participant should be better able to:

• Point 1

• Point 2

• Point 3

**Accreditation and Credit Designation Statements**

Case Western Reserve University School of Medicine is accredited by the Accreditation Council   
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Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Planning Committee Disclosure *(select one)***

[Insert Name reported no financial relationships relevant to this activity.



[Insert Name is a consultant for [insert company name], paid speaker for [insert company name], received grant research support from [insert company name], and/or has an ownership interest in [insert company name].



**Speaker Disclosure *(select one)***

[Insert name and role (speaker/moderator)] reported no financial relationship relevant to this activity.



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*We gratefully acknowledge [insert] for their support of this program.* [Use when commercial support is provided for program]

For additional information regarding this presentation, please contact [insert name of coordinator, phone #, email].



TITLE | CID #

DATE

Time

Location

Location

Speaker name, Title

*Speaker affiliation*

Title of Session