

 **MetroHealth** Continuing Medical Education | Commercial Support Agreement

has provided a grant to THE METROHEALTH FOUNDATION, in

support of The MetroHealth System's Department of _____ for \$ _____ to be used toward the
cost of providing the CME activity _____ CID#

to be held on _____ at MetroHealth Medical Center.

The representative of

Name

Address

Phone

The MetroHealth System Activity Director

Name

Address 2500 MetroHealth Drive
Cleveland, OH 44109

Department of

Phone

Acknowledge that this grant is awarded and will be handled in accordance with the current Guidelines of the Pharmaceutical Manufacturer's Association and the American Medical Association, the Commercial Support Standards of the Accreditation Council for Continuing Medical Education, and the Guidelines and policies of the MetroHealth System CME Office. Five percent of each donor gift is designated to the MetroHealth Fund to help support philanthropic initiatives of The MetroHealth System.

We have read the Policy on Commercial Support for Continuing Medical Education Activities.

Signature: _____ Date: _____
Representative

Signature: _____ Date: _____
Activity Director

RETURN A SIGNED COPY of this agreement to the activity director listed above for each grant received.

Make Checks Payable to: The MetroHealth Foundation (Attach a copy of this agreement to each check)

The MetroHealth Foundation Tax ID #34-6607695

Questions may be directed to:

Kimberly Montgomery, Coordinator, CME Accreditation
MetroHealth Medical Center
CME Office, Rm. A-109
(216) 778-5281