



Professional Acknowledgment for Continuing Education

7910 Woodmont Avenue,

Suite 530 Bethesda, MD 20814

301-657-2768, 301-657-2909 fax

**SPEAKER CREDENTIALS**

Name: \_\_\_\_\_

Present Position: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ email: \_\_\_\_\_

Specialty: \_\_\_\_\_

*(Immunology, Regulatory Affairs, Microbiology, etc.)*

Degree(s): \_\_\_\_\_

Granting Institution/Year: \_\_\_\_\_

\_\_\_\_\_

Certifications/Agency: \_\_\_\_\_

\_\_\_\_\_

Professional Program(s)/Year Completed: \_\_\_\_\_

\_\_\_\_\_

Providing Institution: \_\_\_\_\_

Other relevant experience \_\_\_\_\_

\_\_\_\_\_