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**CFPC Representative Confirmation**

This form is to be completed by one CFPC member who is listed in the application as a member of the scientific planning committee.

Program Title: Enter Program Title

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| --- | --- |
| As a family physician and member of the College of Family Physicians of Canada, I hereby certify that I had substantial input into the planning and development of this program. My involvement has been as follows: | |
| Name: Enter Name of CFPC Member | Date: Enter Date |
| Signature: | CFPC #: Enter CFPC Member Number. |

Continuing Professional Development

Schulich School of Medicine & Dentistry, Western University

Health Sciences Addition Room 140

Rev. Oct 2021