KELLER MEDICAL, INC. PARTNERS IN EDUCATION

Academic Program Application

Program Information

Institution or Course Name: ______________________________

Course Location: ______________________________

Program Chair: ____________________ Email: ____________________

Direct Phone: ____________________ Website: ____________________

Instructors:

____________________ ____________________
Name *Email*

____________________ ____________________
Name *Email*

____________________ ____________________
Name *Email*

Nature of Program:

☐ Residency / Fellowship — Estimated # of Residents: ________ Estimated # of Fellows: ________

☐ CME Program — Frequency of Courses: ____________________ Anticipated Date of Next Course: ____________________ Estimated # of Students: ________

☐ Other — Course Description ______________________________

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Contact Information

Course Materials Coordinator: ______________________________

Phone: ____________________ **Email:** ____________________

Shipping Address for Materials: ______________________________

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Program Agreement

☐ **I agree to provide name and contact information for all students participating in any programs outlined above for which teaching materials have been provided.**

Signed: ______________________________ **Dated:** ____________________

Print Name: ______________________________

Keller Medical, Inc.:

Accepted by: ______________________________ **Date:** ____________