FOR OFFICE USE:
Date/Time Rec'd: _____ By: _____
Date Payment Rec'd _____ By: _____
Date CE Record Processed _____ By: _____

wakeAHEC
BETTER HEALTHCARE THROUGH EDUCATION

3261 Atlantic Avenue, Suite 212
Raleigh, North Carolina 27604-1657
Phone: 919-350-8547
Fax: 919-350-0470
www.wakeahec.org

REQUEST FOR DUPLICATE CE CREDIT CERTIFICATE

Please **PRINT** legibly.

Date of Program: _____ **Name of Program:** _____

Preferred Email **(REQUIRED)**: ○ Dr. ○ Mr. ○ Mrs. ○ Ms.

Name: _____
First MI Last

Home Address: _____
Street Address

_____
City State Zip Code

Employer or Practice Name: _____

Work Address: _____
Street Address City State/Zip Code

Work Phone: _____ **Degree(s)/Credential(s):** _____
(e.g., MD, PA, NP, etc.)

Clinical Specialty: _____ **Job Title:** _____
(Internal Medicine, Urology, etc.)

Duplicate Certificate Fee: $15 (due at time of request)

Method of Payment

○ Check: Make checks payable to Wake AHEC.
Mail to: Wake AHEC, 3261 Atlantic Avenue, Suite 212
Raleigh, NC 27604-1657

○ Credit Card: When paying by credit card, call 919-350-8547 to provide your credit card payment information.

CE Certificates will be emailed within 7 – 10 business days.

Email address: _____

******CE Certificates will be sent by email only.******