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**Michigan Center for Clinical Systems Improvement**

**233 E. Fulton Street, Suite 20**

**Grand Rapids, Michigan 49503**

**CERTIFICATE OF PARTICIPATION**

**This certifies that:**

**Enter Your Name**

**(Name of Participant)**

**has participated in the educational activity entitled:**

**Team-Based Care**

Enter Date of Training (Virtual) Grand Rapids, Michigan

 (Date of Activity) (City/State of Activity)

and is awarded up to **7.50** credits.

**The AAFP has reviewed Team Based Care, and deemed it acceptable for AAFP credit. Term of approval is from 10/23/2021 to 10/22/2022. *Physicians should claim only the credit commensurate with the extent of their participation in the activity.***

I participated in *Enter # of Credits Claimed* credits of this CME activity.

  **Susan Vos RN, BSN, CCM**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Enter Date  **Activity Director – MiCCSI**

 Participant’s Signature Date

 10/23/2021

 Date