Geriatric Orthopaedic Fracture Conference  
Registration Form

Please type or print clearly. A name badge and Statement of Participation are generated from this document.

Name ____________________________________________________________

Affiliation ____________________________________________ Department _______________________

Address ________________________________________________________ ○ HOME ○ OFFICE

City __________________ State __________ Zip ________________

Telephone ____________________________ E-mail ____________________________

Receipts, confirmations and driving directions are e-mailed from our office. Please provide your e-mail address and print clearly.

DEGREE ○ MD ○ DO ○ PhD ○ PA ○ RN ○ PharmD/RPh ○ Other-specify ____________________________

SPECIALTY ○ Geriatric Medicine ○ Family Medicine/ Subspecialty ____________________________
○ Orthopaedic Surgery ○ Internal Medicine / Subspecialty ____________________________
○ Hospital Medicine ○ Other ____________________________
○ General Surgery

REGISTRATION FEES

<table>
<thead>
<tr>
<th></th>
<th>Early Rate</th>
<th>Regular Rate</th>
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</thead>
<tbody>
<tr>
<td>On or before April 1, 2021</td>
<td>$350</td>
<td>$400</td>
</tr>
<tr>
<td>On or after April 2, 2021</td>
<td>$250</td>
<td>$300</td>
</tr>
<tr>
<td>Medical Industry Professionals</td>
<td>$415</td>
<td>$465</td>
</tr>
<tr>
<td>Residents/Fellows/Students Fee-Waived</td>
<td>Fee-Waived</td>
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Published Attendee List: May we include your name, degree, clinic, city, state, country (no email, no mailing address) on the registrant list available to planning committee, exhibitors, speakers, and attendees of this conference only? ○ Yes ○ No

Have you attended this activity in the past? ○ Yes ○ No

What led you to register for this activity? ○ Email announcement ○ Colleague/Friend ○ Employer/Course Director
○ Mailed Flyer/Brochure ○ Other: ____________________________

Do you have a preference for receiving information about upcoming CE activities? ○ Yes, by email only ○ Yes, by mail only ○ Yes, by email or mail ○ No, do not contact me

Group Registration
A minimum of 3 registrants are required for a group discount of $20 per person to be deducted from the corresponding registration fee listed above. Please send all registrations together with check payment. NO refunds will be issued if a person from a group has to cancel or does not show up at the conference. Normal refund policy applies for complete group cancellations.

SPECIAL REQUESTS Special needs, such as dietary restrictions, lactation room, etc., should be requested in advance. These requests cannot always be honored on site. Dietary: ____________________________________________ Other: ____________________________________________

Please be aware that CPD may take photos/video of participants at CPD events and these may appear in CPD’s promotional materials. Your attendance constitutes your permission and consent for photography and video subsequent usage

TO REGISTER
Mail this registration form and your check, payable to Regents of the University of Minnesota, to: Office of Continuing Professional Development, University of Minnesota Medical School, MMC 293, Mayo Memorial Bldg. Room G-254, 420 Delaware Street SE, Minneapolis, MN 55455. For credit card payment, register online at z.umn.edu/Geriatric

CANCELLATION POLICY
In the event you need to cancel your registration, the registration fee, less a $50 administrative fee, will be refunded if you notify us by 4:30 p.m. CST on May 7, 2021. No refunds will be made after this date. If you have any questions, please contact our office at (612) 626-7600 or (800) 776-8636, or e-mail us at cme@umn.edu.

University of Minnesota
Continuing Professional Development