Annual Updates in Neurosciences for Primary Care
Registration Form

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

Name ____________________________

Affiliation ____________________________ Department ____________________________

Address ____________________________________________________________ HOME NO 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

☐ APRN (NP, CNS, CRNA, CNM) ☐ PharmD/RPh ☐ Other-specify ____________________________

SPECIALTY

☐ Family Medicine/ Subspecialty ____________________________

☐ Internal Medicine / Subspecialty ____________________________

☐ Other ____________________________

REGISTRATION FEES

<table>
<thead>
<tr>
<th></th>
<th>Early Rate</th>
<th>Regular Rate</th>
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<tbody>
<tr>
<td></td>
<td>Now to Jan 30</td>
<td>After Jan 31</td>
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<tr>
<td>☐ Physician</td>
<td>$200</td>
<td>$250</td>
</tr>
<tr>
<td>☐ Other Healthcare Professional</td>
<td>$150</td>
<td>$200</td>
</tr>
<tr>
<td>☐ Medical Industry Professional</td>
<td>$300</td>
<td>$350</td>
</tr>
<tr>
<td>☐ Resident/Fellow/Student</td>
<td>$50</td>
<td>$75</td>
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</tbody>
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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

How did you hear about this conference?

☐ Employer ☐ Email ☐ Colleague/Friend ☐ Website ☐ Flyer ☐ Other: ________________

Mailing List: May we contact you about future course and program offerings? You will only be contacted by programs whose courses or conferences you have attended. Your information will not be shared with outside parties. You may change your selection at any time. ☐ Yes, by email ☐ Yes, by 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/NeuroPC

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 March 14, 2020. 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.