Jefferson
HEALTH IS ALL WE DO

5th Annual Palliative Care Spring Symposium
*Dorrance H Hamilton Building * 1001 Locust Street * Philadelphia, PA 19107*
Friday, June 3, 2016

INSTRUCTIONS: Please complete this entire form and return it to the Office of CME either via fax or by mail along with payment. If you do not have an account set up in our CPD@JeffLEARN webpage, a profile will be set up for you. An email will be sent to you with additional instructions on how to access your account.

FOR ADDITIONAL COURSE INFORMATION, PLEASE ACCESS THE CPD@JEFFLEARN WEBPAGE AT HTTPS://CME.JEFFERSON.EDU/

_____

Title (Dr, Mr, Ms, Mrs) First Name MI Last Name Personal Title (II, Jr)

_____

Degree (MD, PhD, BSN, MSN, MBA, etc) Specialty/Sub Specialty

_____

Company/Organization Name Position/ Job Title

_____

Address City State Zip Code

_____

Mobile Phone Number* Other Phone Email Address

***your mobile phone number will not be disseminated and is only intended to record attendance at selected activities.**

FOR PHYSICIANS ONLY: NPI#_____ State Licensure # (only 1 state needed) _____

Registration Fees - *Registration Deadline is: June 1, 2016*

Registration will not be processed unless full payment is received.

One Jefferson and SKCC Members - Plenary Lecture ONLY (8:00AM – 10:00AM) ONLINE REGISTRATION ONLY: https://cme.jefferson.edu/content/jefferson-palliative-care-special-grand-rounds	
ALL DAY REGISTRATION *(Includes all conference materials, CE Certificates, continental breakfast, lunch and refreshments during break. See webpage for additional information)*	
□ $100 Practicing Physicians	□ $75 Nurse / Nurse Practitioners
□ $75 Allied Health Professionals	□ $50 One Jefferson, Sidney Kimmel Cancer Network Methodist, Abington, Aria and Kennedy Faculty & Staff

PAYMENT: Please make check payable to **Sidney Kimmel Medical College at Thomas Jefferson University, Office of CME**, or provide Credit Card Information. Do not send cash. Registration will not be processed unless full payment is received.

□ Check is enclosed. Check Number: _____ Amount $ _____
Check should be mailed to 1020 Locust Street – Suite M5, Philadelphia, PA 19107

I hereby authorize use of my: ☐ Visa ☐ Mastercard Amount $ _____

Account Number: _____ Exp Date: _____

***Billing Address (if different from above)*: _____**

□ ***Please do not include me in upcoming events mailing lists.***

For more information, please call the Office of CME at 1-888-JEFF-CME or 215-955-6992

If you have any special needs, please contact the CME Office by Wednesday, June 1, 2016 at 1-888-JEFF-CME or 215-955-6992.