



5th Annual Neurocritical Care Symposium: A Practical Approach

January 29-30, 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: January 27, 2016*

	Friday <u>AND</u> Saturday	Friday <u>ONLY</u>	Saturday <u>ONLY</u>
Physicians	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$175.00	<input type="checkbox"/> \$300.00
Other Healthcare Professionals & Non Jefferson Fellows and Residents	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$125.00	<input type="checkbox"/> \$300.00
Jefferson, Methodist, and Abington Faculty & Staff	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$60.00	<input type="checkbox"/> \$300.00

To register please use one of the following options, based on payment method.

Registration will not be processed unless full payment is received.

CHECK: Please make check payable to SKMC at TJU, Office of CME. Do not send cash.

Mail to: EMG Conference 2016 - Office of CME; 1020 Locust Street, Suite M-5; Philadelphia, PA 19107

Check is enclosed. Check Number: _____

Credit Card: If paying by credit card, we suggest you register online (<https://cme.jefferson.edu/>). However, you may fax this form with credit card payment to (215) 923-3212

I hereby authorize use of my: Visa MasterCard Amount \$ _____

Account Number: _____ Expiration Date: _____

Cardholder's Name: _____ Cardholder's Signature: _____

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 [February 3, 2016](#) at 1-888-JEFF-CME or 215-955-6992.