Jefferson
Philadelphia University + Thomas Jefferson University

8th Annual Jefferson Neurocritical Care Symposium

*Dorrance H. Hamilton Building * 1001 Locust Street, Philadelphia, PA 19107*

Friday-Saturday, February 22-23, 2019

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 February 20, 2019*

	Friday ONLY	Saturday ONLY	Friday AND Saturday
Physicians	□ $175.00	□ $350.00	□ $500.00
Nurse, Nurse Practitioner and Allied Health Professionals, Non Jefferson Residents & Fellows	□ $125.00	□ $350.00	□ $450.00
Jefferson Neuroscience Network* - Physician	□ $100.00	□ $350.00	□ $425.00
Jefferson Neuroscience Network* - Nurse, Nurse Practitioner and Allied Health Professionals	□ $85.00	□ $350.00	□ $400.00
Jefferson Health (Abington, Aria, Einstein, Kennedy, Magee Rehabilitation Hospital, Main Line Health & Methodist) - Faculty & Staff	□ $60.00	□ $350.00	□ $400.00

Registration will not be processed unless full payment is received.

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 $ _____
Payment should be mailed to: 1020 Locust Street - Suite M5, Philadelphia, PA 19107 ATTN: Neurocritical Care Symposium

I hereby authorize use of my: ☐ American Express ☐ 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 February 20, 2019 at 1-888-JEFF-CME or 215-955-6992.