Jefferson
Philadelphia University + Thomas Jefferson University

6th Annual Sleep Medicine Symposium: What's New Under the Moon?

Friday, March 22, 2019

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

INSTRUCTIONS: Please complete this entire form and send it to the Office of CPD along with payment. If you do not have an account in our CPD@JeffLEARN learning management system, a profile will be set up for you. An email will be sent to you with additional instructions on how to access your account.

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) ____________________

PRE-REGISTRATION ENDS WEDNESDAY, MARCH 20, 2019

Choose from 3 breakout sessions ***(subject to availability)***	□ Utilizing the Sleep Laboratory to Determine the Efficacy of Upper Airway Stimulation Therapy
	□ Central Sleep Apnea and Heart Disease: Evaluation and Management
	□ Managing CPAP Noncompliance: Managing Claustrophobia, Anxiety, Mask Leakage, Aerophagia, and Lack of Motivation

Select the registration fee that best fits	□ $125 Practicing Physicians
	□ $95 Nurses
	□ $75 Allied Health Professionals
	□ $75 Non-Jefferson Residents and Fellows
	□ $60 Jefferson Health

Registration will not be processed unless full payment is received.
We do not accept cash. Please use one of the following payment options.

CHECK: □ Check is enclosed. Check Number: ______________________ Amount $______________________
Please make check payable to Sidney Kimmel Medical College at Thomas Jefferson University, Office of CPD.
Mail to: Office of CPD, 1020 Locust Street, Suite M-5; Philadelphia, PA 19107

CREDIT CARD: I hereby authorize use of my: □ Visa □ MasterCard □ American Express Amount $ ______________

Account Number: ____ Expiration Date: ______________________

Cardholder's Name: _____________________________ Cardholder's Signature: ________________________________

Billing address (if different from above): ____

If you need more information or have special needs, please contact the Office of CPD at 215-955-6992.

□ Opt out of upcoming events mailing lists.