

# COURSE REGISTRATION

## OREGON PRACTICE ENHANCEMENT FORUM

September 12-13, 2008

Mount Bachelor Village Resort, Bend, Oregon

### 1. Identify Your Team of Three

Family Physician's Name: \_\_\_\_\_

Member ID#: \_\_\_\_\_

Check here if Member ID# does not apply

E-mail Address: \_\_\_\_\_

Front Office Staff Person's Name: \_\_\_\_\_

Professional Title: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Back Office Staff Person's Name: \_\_\_\_\_

Professional Title: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### 2. Provide your Practice Information and answer a few basic questions.

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(your teams' pre-work will be sent here).

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Does your practice have regular team meetings?

(960) Yes  (961) No

If so who participates, and how often?

\_\_\_\_\_  
\_\_\_\_\_

Does your practice have a way to identify your patients with a specific chronic illness (e.g. diabetes)?  (962) Yes  (963) No

### 3. Select Your METRIC Module.

This is the clinical topic of focus for your teams practice improvement project. (Choose one topic)

(964) Asthma  (965) CAD  (966) COPD  
 (967) Diabetes  (968) Geriatrics

4. Attach a one-page essay describing your practices experience with quality improvement and what you hope to derive from the Practice Enhancement Forum.

### 5. Registration Fees

	By 7/03/08 (Earlybird)	By 8/01/08 (Final Registration)
<input type="checkbox"/> Member Team	\$245	\$495
<input type="checkbox"/> Non-member Team	\$545	\$995

### 6. Special Needs

If you have physical or dietary requirements which require accommodation in order to fully participate in this activity or you need special accommodations for breastfeeding during the hours of the program, please list below.

Please list need: \_\_\_\_\_

### 7. Housing Accommodations

Information for securing hotel reservations will be provided with the team's confirmation letter. Please indicate if you team will need make reservations:

(969) Yes we will need hotel reservations.

Number of rooms needed \_\_\_\_\_

(970) No we will not need hotel reservations.

### 8. Method of Payment

Enclose check or indicate credit card information for the registration fee. Credit cards will not be charged until the practice team is accepted.

**Registration forms will be accepted only when accompanied by full payment.**

Visa  Mastercard  Discover  American Express

Check enclosed (*payable to AAFP*)

Card Number: \_\_\_\_\_

Exp Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Cancellation policy — The AAFP must receive notice of cancellation no later than August 22. Requests for full cancellations will be refunded less a \$50 administrative fee. See the entire policy online at [www.aafp.org/cmecancellations](http://www.aafp.org/cmecancellations).**

Submit your registration with appropriate payment and essay to:

American Academy of Family Physicians

Attention: Terri Vokins

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FAMILY PHYSICIANS