COURSE REGISTRATION

GEORGIA PRACTICE ENHANCEMENT FORUM

March 26-27, 2010
Hilton Atlanta Airport, Atlanta, Georgia

Registration Deadline is February 5, 2010

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' prework will be sent here.)

City: ______________________________

State, Zip: ______________________________

Phone: ______________________________

Fax: ______________________________

❑ (957) Number of physicians in your practice: _________

Does your practice have regular team meetings?
❑ (958) Yes ❑ (959) 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)? ❑ (960) Yes ❑ (961) No

3. METRIC Module: This is the clinical topic of focus for your teams practice improvement project.

❑ (964) Asthma ❑ (967) Diabetes ❑ (969) Depression
❑ (965) CAD ❑ (968) Geriatrics ❑ (970) Hypertension
❑ (966) COPD

4. Practice Essay

Please attach a brief essay describing your practice's experience with quality improvement and what you hope to derive from the PEF. This information is shared with PEF faculty.

5. Registration Fees

	On or before 1/08/10 (Early bird)	By 2/05/10 (Final Registration)
❑ Member Team	$245	$495
❑ Non-member Team	$545	$995

6. Special Needs

If you have physical or dietary restrictions, please mark the appropriate boxes below.

❑ (950) Vegetarian
❑ (951) Vegan
❑ (952) Gluten Free
❑ (953) Wheelchair Accessibility
❑ (954) Hearing Impaired
❑ (955) Lactation Room
❑ (956) Other — an AAFP staff member will contact you.

7. Housing Accommodations

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

❑ (962) Yes, we will need to make hotel reservations.

Number of rooms needed ___________

❑ (963) 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 March 5, 2010. Requests for full cancellations will be refunded less a $50 administrative fee. See the entire policy online at www.aafp.org/cmecancellations.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Submit your registration with appropriate payment to:
American Academy of Family Physicians
Attention: Terri Vokins
11400 Tomahawk Creek Parkway, Leawood, KS 66211
Phone: 800.274.2237, Ext. 4168 • Fax: 913.906.6078 • E-mail: tvokins@aafp.org

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