

COURSE REGISTRATION

IOWA PRACTICE ENHANCEMENT FORUM

June 11 –12, 2010

Sheraton West Des Moines, West Des Moines, Iowa

Registration Deadline is
April 23, 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 3/26/10 (Early bird)	By 4/23/10 (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 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 May 21, 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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