COURSE REGISTRATION

IDAHO PRACTICE ENHANCEMENT FORUM

September 25-26, 2009
Doubletree Hotel Boise-Riverside, Boise, Idaho

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

	On or before 717/09 (Earlybird)	**By 8/14/09 (Final Registration)**
❑ Member Team	$245	$495
❑ 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 your team will need to make reservations:

❑ (969) Yes we will need to make 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 September 4, 2009. 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 and essay 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