

# COURSE REGISTRATION

## MINNESOTA-NORTH DAKOTA PRACTICE ENHANCEMENT FORUM

October 22-23, 2010

Arrowwood Resort & Conference Center, Alexandria, Minnesota

Registration Deadline is  
September 3, 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 8/06/10 (Early bird)	By 9/03/10 (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 October 1, 2010. 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).**



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](mailto:tvokins@aafp.org)

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