

COURSE REGISTRATION

INDIANA PRACTICE ENHANCEMENT FORUM

November 14-15, 2008
Marriott Indianapolis Downtown Hotel, Indianapolis, Indiana

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 team's 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 9/5/08 (Earlybird)	By 10/3/08 (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 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 October 24. Requests for full cancellations will be refunded less a \$50 administrative fee. See the entire policy online at www.aafp.org/cmecancellations.

Submit your registration with appropriate payment and essay to:

American Academy of Family Physicians

Attention: Terri Vokins

11400 Tomahawk Creek Parkway, Leawood, KS 66211

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