AAFP CME COURSE REGISTRATION

Register online at www.aafp.org/cmebymonth

Course title:_____

Reg Type: _____

Reg Fee $_____ (see individual course pages)

Date: _____

AAFP Member ID #: _____

Name: _____

Nickname (badge purposes): _____

Degree: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

E-mail (REQUIRED): _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

GO Green! with AAFP

The AAFP is focused on providing the best course resources available, while reducing environmental impact.

Your registration fee includes access to course materials online, which are available approximately one week prior to the course start date. Additional information and instructions will be provided by email.

Disclaimer: If you register for this meeting at the discounted member registration fee, you will be required to be an AAFP member on the date of the meeting. If you are no longer a member on the date the meeting starts, you will be asked to remit payment of the nonmember registration fees that were in place at the time you registered or to reinstate your AAFP membership by paying applicable dues.

Optional Sessions

(If applicable, please list all sessions you wish to attend.)

	Optional Session	Price
# _____	Name _____	$ _____
# _____	Name _____	$ _____
# _____	Name _____	$ _____

Special Needs

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

- ☐ (950) Vegetarian
- ☐ (951) Gluten Free
- ☐ (952) Wheelchair Accessibility
- ☐ (953) Hearing Impaired
- ☐ (954) Lactation Room

OPT IN

- ☐ (998) I want to have my name, city and state included in attendee lists.
- ☐ (999) I want to be included on the list provided to exhibitors, supporters and in-kind supporters who may provide follow-up communications following the course.

Method of Payment

Enclose check or indicate credit card information for the registration fee. ***(Payment is expected to accompany this form.)***

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

☐ Check enclosed ***(payable to AAFP)***

Total due: $_____

Name on Card:_____

Card Number: _____

Exp Date: _____ CVV:_____

Signature: _____

Photography and recording

The AAFP may take photographs and/or record audio and video at this event. By attending, you consent to the use of any photographs, audio, and video recordings of you by the AAFP and its designees in AAFP communications and promotions, or for any other lawful purpose.

The AAFP must receive notice of cancellation no later than 21 days prior to the start of the meeting. Requests for full cancellations will be refunded less a $50 administrative fee. See the entire policy online at www.aafp.org/cmecancellations.

If you plan to register for more than one course, please make a copy of this form and submit separately.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Return with payment or call:
American Academy of Family Physicians
Attn: Member Resource Center
11400 Tomahawk Creek Parkway, Leawood, KS 66211
Phone: (800) 274.2237 • Fax: (913) 906.6075 • Email: aafp@aafp.org