

# COURSE REGISTRATION

Direct Primary Care Summit • July 13-15, 2018

Indianapolis Marriott Downtown | Indianapolis, Indiana

Register online at  
[www.dpcsummit.org](http://www.dpcsummit.org)

AAFP Member ID #: \_\_\_\_\_

Name: \_\_\_\_\_

Nickname (badge purposes): \_\_\_\_\_

Degree: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email (REQUIRED): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

## Registration

	On or Before 6/15/18	After 6/15/18
<input type="checkbox"/> Conference Registration Fee	\$325	\$525
<input type="checkbox"/> One-day Access Fee	\$200	\$200
<input type="checkbox"/> Medical Resident/Student Registration Fee	\$150	\$150

1) What stage is your practice in transitioning to a DPC model?

- Researching to see if the model would be a viable option for me
- In the process of opening a new DPC practice
- Currently transitioning my practice
- Currently working in a DPC practice model
- N/A

2) What is your current employment status?

- In residency
- Medical school
- Employed practicing physician
- In an administrative function within a larger system
- Solo/Small practice owner
- Partial owner
- N/A

3) Which of the following describes you?

- Physician
- Clinical Provider—NP, PA
- Clinical Staff—RN, LPN, MA
- Business/Practice Administrator
- Non-clinical Practice Support Staff
- Resident
- Student
- Education
- Allied Health Professional
- Health Insurance Representative
- N/A

4) Do you belong to a partnering organization? (Check all that apply)

- American Academy of Family Physicians
- American College of Osteopathic Family Physicians  
AOA# \_\_\_\_\_
- Family Medicine Education Consortium
- N/A

## Special Needs

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

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

## OPT IN

- (998) I want to have my name and mailing address 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

Notice regarding photography and/or audio/video recording at this event. By attending, you consent to the use of any photographs, audio, and video recordings of you by the AAFP, ACOFP, or FMEC and its designees in communications and promotions, or for any other lawful purpose.

**The AAFP must receive notice of cancellation no later than June 22, 2018. 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).**

## Return with appropriate 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](mailto:aafp@aafp.org)

**Have you made your hotel reservation? Book your room by June 14, 2018 for a discounted rate. Contact the hotel at (317) 822-3500.**

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