COURSE REGISTRATION

Direct Primary Care Summit • June 15-17, 2017

Crystal Gateway Marriott • Washington, D.C.

Register online at 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 5/15/17	After 5/15/17
☐ Conference Registration Fee	$325	$425
☐ One Day Access Fee	$200	$200
☐ Resident/Student Registration Fee	$175	$175

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
2) What is your current employment status?
   - ☐ In residency
   - ☐ Employed practicing physician
   - ☐ In an administrative function within a larger system
   - ☐ Solo/Small practice owner
   - ☐ Partial owner
3) What is the current size of your practice?
   - ☐ Solo physician
   - ☐ 2-5 physicians
   - ☐ 5+ physicians
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
5) Do you plan on participating in the Advocacy Day on Thursday, June 15?
   ☐ Yes ☐ No

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 May 21, 2017. Requests for full cancellations will be refunded less a $50 administrative fee. See the entire policy online at 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

Have you made your hotel reservation? Book your room by May 18, 2017 for discounted rate. Contact the hotel at (703) 920-3230.

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

acofp American College of Osteopathic Family Physicians

FAMILY MEDICINE EDUCATION CONSORTIUM, INC