

COURSE REGISTRATION

Chief Resident Leadership Development Program

InterContinental Kansas City at the Plaza • Kansas City, MO

For more information, visit
www.aafp.org/chiefresident.

Program Name _____

Program Director's Name _____

*Program Coordinator's Name _____

*Program Coordinator's Phone Number _____

*Program Coordinator's Email Address _____

Address _____

City, State, ZIP _____

***Program coordinator will serve as primary contact and will be copied on all communication to participants.**

Please accept this application and appropriate fees to register for the 2019 AAFP Chief Resident Leadership Development Program. I understand that this application will reserve space for my program's chief resident(s) to attend both a workshop in Kansas City and the follow-up session in Philadelphia in conjunction with the AAFP Family Medicine Experience (FMX). I further understand that I will inform the AAFP of the name(s) of the chief resident participant(s) no later than April 25, 2019.

Registration Fee — \$1,100 per chief resident
Registration includes the Kansas City workshop, Philadelphia workshop, and AAFP Family Medicine Experience.

Session I — May 16-18, 2019 **Choose one:**
Number of Chief Resident Participants: 1 2 3 4

Session II — May 18-20, 2019
Number of Chief Resident Participants: 1 2 3 4

The AAFP must receive notice of cancellation no later than April 26, 2019. Requests for full cancellations will be refunded less a \$50 administrative fee. See the entire policy online at www.aafp.org/cmecancellations.

Chief Resident 1 Name _____

Nickname _____

Degree _____

Email _____

Chief Resident 2 Name _____

Nickname _____

Degree _____

Email _____

Chief Resident 3 Name _____

Nickname _____

Degree _____

Email _____

Chief Resident 4 Name _____

Nickname _____

Degree _____

Email _____

Method of Payment

Enclose check or indicate credit card information for the registration fee. **(A \$1,100 registration fee per chief resident space is expected to accompany this application to ensure participation in this course.)**

Visa MasterCard Discover American Express

Check enclosed (**payable to AAFP**)

Total due: \$ _____

Name on Card: _____

Card Number: _____ CW: _____

Exp. Date: _____

Signature: _____

HAVE YOU MADE YOUR HOTEL RESERVATION?
Don't forget the deadline is April 15, 2019. Hotel information is available at www.aafp.org/chiefresident or call the hotel at (866) 856-9717.



Return to:
American Academy of Family Physicians
Attn: Sam Pener
11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680
Phone: (913) 906-6359 • Fax: (913) 906-6105
spener@aafp.org
MED19020258