Sidney Kimmel Medical College
at Thomas Jefferson University

Register Now!

Focused Workshop in Endoscopy - RFA/EMR Resection Techniques: An In-Depth Review with Live Observations and Hands-On Practice
****Tuesday, February 10, 2015****

☐ Male ☐ Female

Last Name **First Name** **MI**

Title (Dr., Mr., Ms.) **Personal Title (II, Jr)** **Degree (MD, PhD, BSN, MSN, MBA, etc)** **Specialty**

Affiliation/Organization/Department **Mailing Address**

City **State** **Zip**

Telephone ☐ **Work** ☐**Home** ☐**Cell** **Fax** **Email**

___ _____ _____ _____

Web ID (Please provide the last four digits of your Social Security Number as your Web ID. This will allow you to access your CME transcript at anytime after the course.)

☐ ***Please do not include me in upcoming events mailing lists.*** ***Are you a Jefferson Medical College Alum?***
☐ ***Yes*** ☐ ***No*** ***If yes, what year?*** _____

Please read each of the following statements.
Your signature below indicates your understanding and compliance:

☐ I certify that I am not receiving funds from any commercial entity to support my travel to this course.

AND

☐ I understand that I will be required to complete a HIPAA Confidentiality Agreement at the beginning of the course in order to participate

Signature: _____ **Date:** _____

Registration Fees ***Registration Deadline is: February 3, 2015***

☐ **$500 Practicing Physician**	☐ **Team Rate** – *1 Physician and 1 Nurse/Allied Health Professional from the same institution - please contact the CME Office to register*

To register, please use one of the following options:

- **Register Online:** http://jeffline.jefferson.edu/jeffcme
- **Fax:** You may fax this form with credit card payment to (215) 923-3212
- **Mail:** **RFA Workshop 2015** - Office of CME; 1020 Locust Street, Suite M-5; Philadelphia, PA 19107
- **Payment:** Please make check payable to **SKMC/Jefferson, Office of CME**, or provide Credit Card Information. Do not send cash. **Registration will not be processed unless full payment is received.**

☐ Check is enclosed. Check Number: _____

I hereby authorize use of my: ☐ Visa ☐ MasterCard Amount $ _____

Account Number: _____ Expiration Date: _____

Cardholder's Name: _____ Cardholder's Signature: _____

Billing Address *(if different from above)* _____

For further information, please call the Office of CME at 1-888-JEFF-CME or 215-955-6992

If you have any special needs, please contact the CME Office by February 3, 2015 at 1-888-JEFF-CME or 215-955-6992.