Register Now!

ERCP Skills: An In-depth Review with Live Observation - Thursday, September 18, 2014

______________________________ ☐ 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: September 12, 2014***

☐ **$125 Practicing Physicians**	☐ **$125 Nurses & Nurse Practioner**	☐ **$125 Allied Health Professionals**

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:** **ERCP Course 2014** - 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 September19, 2014 at 1-888-JEFF-CME or 215-955-6992.