REGISTRATION FORM

REGISTER ONLINE AT www.cme.hsc.usf.edu/mspdenewyork
REGISTER BY FAX: (813) 974-3217
RETURN REGISTRATION FORM AND PAYMENT TO:
UNIVERSITY OF SOUTH FLORIDA
HEALTH PROFESSIONS CONFERENCING CORPORATION (HPCC) PO BOX 864240, ORLANDO, FL 32886-4240
A CONFIRMATION LETTER WILL BE SENT UPON RECEIPT OF YOUR REGISTRATION AND PAYMENT (NO REGISTRATION IS CONFIRMED WITHOUT FULL PAYMENT)

NAME

GENDER:  
- MALE
- FEMALE

TITLE (MD, RN, ETC.)  
SPECIALTY

ADDRESS  
CITY  
STATE  
ZIP

DAYTIME PHONE  
FAX NUMBER

EMAIL ADDRESS

TYPE OF CREDIT REQUESTED:  
- PHYSICIAN
- RESIDENT
- NURSE
- PA
- FELLOW
- OTHER _______________

LICENSE # REQUIRED FOR NURSES ________________________________

“BURNING QUESTION” I WOULD LIKE THE FACULTY TO ADDRESS DURING THE PROGRAM:

REGISTRATION FEES

REGISTRATION FEE  
$99.00  
$_________

CREDIT CARD:  
- VISA
- MASTERCARD
- AMEX

IN THE AMOUNT OF $ ____________________________

CARD NUMBER

ENCLOSED IS MY CHECK MADE PAYABLE TO: USF HPCC IN THE AMOUNT OF $ ____________________________

MAIL TO ADDRESS LISTED ABOVE.

PN2010107D/1170