



3 WAYS TO REGISTER!

ONLINE • FAX • MAIL

REGISTER ONLINE AT
 WWW.CME.HSC.USF.EDU/ALLERGY_IMMUNOLOGY
 REGISTER BY FAX: (813) 974-3217
 MAIL REGISTRATION FORM AND PAYMENT TO:
 ATTN: SM 2009 372 1115
 USF HPCC
 OFFICE OF CONTINUING PROFESSIONAL DEVELOPMENT
 P.O. BOX 864240
 ORLANDO, FL 32886-4240

 FIRST NAME MIDDLE INITIAL LAST NAME

GENDER:
 MALE
 FEMALE

 TITLE/DEGREES ORGANIZATION

 STREET ADDRESS COUNTY

 CITY STATE ZIP

 DAYTIME PHONE FAX NUMBER

 E-MAIL ADDRESS

PROFESSIONAL PROFILE:
 PHYSICIAN PA NURSE ARNP
 RESIDENT MEDICAL STUDENT
 OTHER _____

 MEDICAL SPECIALTY

 BIRTHDAY (MM/DD)

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

REGISTRATION FEES AND PAYMENT

PHYSICIANS, NURSES, RESIDENTS, FELLOWS,
 ARNPs, PAs: STUDENTS:
 FULL CONFERENCE \$99 \$29
 DINNER SYMPOSIUM ONLY \$59 \$29
 MAIN CONFERENCE ONLY \$59 NO CHARGE
 (RESIDENTS, FELLOWS, AND STUDENTS MUST PROVIDE LETTER
 FROM DEPARTMENT HEAD AS PROOF OF STATUS)

ENCLOSED IS MY CHECK MADE
 PAYABLE TO: **USF HPCC**
 IN THE AMOUNT OF \$ _____

FOR ASSISTANCE, CALL THE OFFICE OF CONTINUING
 PROFESSIONAL DEVELOPMENT AT (813) 974-4296 OR
 1-800-852-5362.

A CONFIRMATION LETTER WILL BE SENT UPON RECEIPT OF
 YOUR REGISTRATION AND PAYMENT (NO REGISTRATION IS
 CONFIRMED WITHOUT FULL PAYMENT)

CREDIT CARD: VISA MASTERCARD AMEX

IN THE AMOUNT OF \$ _____

 CARD NUMBER

 EXP. DATE SECURITY CODE/CCV
(AMEX-4 digits on front, MC/Visa-3 digits on back)

 NAME ON CARD (PRINT)

 SIGNATURE SM 2009 372 1115