

AAFP CME COURSE REGISTRATION

Register online at www.aafp.org/livecme

LIVESTREAM

Please Register Me For:

Course title: _____

Reg type: _____

Date: _____

AAFP Member ID #: _____

Name: _____

Nickname (for badge purposes): _____

Degree: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

E-mail (REQUIRED): _____

Emergency contact name: _____

Emergency contact phone #: _____

Method of Payment

Enclose check or indicate credit card information for the registration fee. **(Payment is expected to accompany this form.)**

Visa Mastercard Discover American Express

Check enclosed **(payable to AAFP)**

Total due: \$ _____

Card Number _____

Security Code _____

Name on Card _____

Expiration (MM/YY) _____

Signature: _____

The AAFP must receive notice of cancellation no later than 21 days prior to the start of the meeting. Requests for full cancellations will be refunded less a \$50 administrative fee. See the entire policy online at www.aafp.org/cmecancellations.

Disclaimer: If you register for this meeting at the discounted member registration fee, you will be required to be an AAFP member on the date of the meeting. If you are no longer a member on the date the meeting starts, you will be asked to remit payment of the nonmember registration fees that were in place at the time you registered or to reinstate your AAFP membership by paying applicable dues.

MKT19081027



Return with appropriate payment or call:

American Academy of Family Physicians

Attn: Member Resource Center

11400 Tomahawk Creek Parkway, Leawood, KS 66211

Phone: (800) 274-2237 • Fax: (913) 906.6075

E-mail: aafp@aafp.org