National Foundation for Infectious Diseases®

# REGISTRATION FORM
# CLINICAL VACCINOLOGY COURSE

NOVEMBER 3-4, 2017

BETHESDA MARRIOTT, 5151 POOKS HILL ROAD, BETHESDA, MD 20815

Please complete and return this form by email to idcourse@nfid.org

Please print clearly or type:

Last name | First name | Middle initial | Nickname (for badge)

Professional title | Employer

**Degree(s)** (circle all that apply)

BA BS MA MD MPH MS NP PharmD PhD RN Other (please specify):_____

Mailing Address

City | State | Postal code | Country

Telephone | E-mail address

❑ Do not include my contact information on the Attendee Roster.

**Profession** (circle one)

Nurse
Nurse Practitioner
Pharmacist
Physician
Physician Assistant
Other (Please Specify): _____

**Practice Setting** (circle one)

Academia
Government
Hospital/Health System
Industry
Pharmacy
Private Practice
Public Health
Other (Please Specify): _____

**Primary Specialty** (circle one)

Administration/Management
Adolescent Medicine
Clinical Research
College Health
Epidemiology
Family Medicine
Geriatrics
Internal Medicine
Obstetrics/Gynecology
Pediatrics
Pediatric Infectious Disease
Pharmacy
Public Health
Research
Travel Medicine
Other (Please Specify): _____

**Continuing Education (CE) credit requested:** (circle one)

CME CNE CPE Certificate of Attendance

**What percentage of the work day are you involved in direct patient care?** (circle one)

0% 1-25% 26-50% 51-75% 76-100%

**How did you hear about this course?** (circle all that apply)

CDC Colleague E-mail Emory University Facebook LinkedIn Mailing NFID Website Previously Attended

Professional Society (please specify):_____

Other (please specify): _____

**What was the major determining factor in registering for this course?** (circle one)

Content/Topics Continuing Education Cost Faculty Location Networking

Other (please specify): _____

## SPECIAL NEEDS

Please email any special meeting needs, requirements, or dietary restrictions to: **idcourse@nfid.org**

## PAYMENT (circle the amount enclosed)

| REGISTRATION TYPE | Early (by 9/25/17) | Regular (after 9/25/17) |
|---|---|---|
| General (CME, CPE, Certificate of Attendance) | **$725** | **$825** |
| Nurse† (CNE Credit) | **$475** | **$575** |
| Daily (select one) | **$400** | **$500** |
| | ❑ FRIDAY ❑ SATURDAY | |

*Early registration, including payment, must be post-marked by 9/25/17.*

For group registrations, please contact NFID at IDcourse@nfid.org

*† Nurses must provide a copy of a valid nursing license.*

❑ Check or money order drawn on US funds **(made payable to NFID)** enclosed in the amount of $_____

*Mail checks to: NFID, 7201 Wisconsin Avenue, Suite 750, Bethesda, MD 20814*

❑ Please bill my credit card in the amount of $_____

Select type of card ❑ Visa ❑ MasterCard

Name as printed on card

Card number | Security Code | Expiration date

Signature

Billing address (if different from mailing address)

## CANCELLATION POLICY

Refunds, less a $75 administrative fee, will be granted only if written notification is received at NFID prior to 5:00 PM ET on **MONDAY, SEPTEMBER 25, 2017**. There will be no refunds for cancellations made after this date. Substitutions may be allowed; however, you must notify NFID in writing prior to **FRIDAY, OCTOBER 27, 2017**. The program organizers reserve the right to cancel this course at any time. In the event of a cancellation of the course, the total registration fee paid will be refunded.