

Acute Care Psychiatry Clinical Review

October 9-11 2008

505 Michigan Avenue

Chicago, Illinois

Submit online registration at <http://www.mayo.edu/cme/> or FAX form with payment to

Mail form and payment to:
 Mayo School of CME
 Plummer 2-60
 200 First Street SW
 Rochester, MN 55905

Phone: 800-323-2688 or 507-284-2509
 Fax: 507-284-0532
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 Email: cme@mayo.edu
 Web site www.mayo.edu/cme

On-line registration is available at: <http://www.mayo.edu/cme>

Contact Information

Name of Registrant - first name, middle name or initial, last name		Degree - select all that apply <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PhD <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> Other - specify	
Name of Institution		Medical Specialty	
Preferred Mailing Address - select one <input type="checkbox"/> Work/Business <input type="checkbox"/> Home			
Work/Business Address - street address		Work Phone - include all country and city/area codes along with complete phone number	
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E-mail Address*		FAX - include all country and city/area codes along with complete phone number	FAX Location (select) <input type="checkbox"/> Work/Business <input type="checkbox"/> Home
<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 5px; font-weight: bold; margin-right: 10px;">SPECIAL NEEDS</div> <div> If you have special assistance needs or dietary restriction, describe here: </div> </div>			

Registration Fee

Physician/Scientist	\$ 750
Residents, Physician Assistants, Nurse Practitioners and Social Workers	\$ 550
TOTAL AMOUNT DUE	\$ _____

Payment Information

<input type="checkbox"/> Check is enclosed in the amount shown at right - make checks payable to Mayo Clinic			Payment Total
Credit Card - select one <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa	Account Number	Exp Date - mo/yr	
Name of Cardholder - as appears on the card	Signature of Cardholder - required X		