2017 MAFP Summer Destination CME Registration Form

Your Registration *please print*

Name: ____

Designation(s): ______________________ Circle one: *Family Physician* *Allied Professional*

Email Address: ______________________ Cell Phone: ______________________

Twitter Handle: ______________________

I require the use of the Mother's Nursing Room : Yes ☐ No ☐

I require special accommodation due to a disability. Please list: ______________________

Special Dietary Needs: ______________________

Attendee Options by Member Type (Add on KSA)

Active Member: AAFP/MAFP			***Resident/ Student Member***
2-Day Pass	**$275**		**No Charge** 2-day ☐ Friday ☐ Saturday ☐
Day Pass Friday	**$175**		
Day Pass Saturday	**$175**		
Non-Member			***KSA Sessions (Formerly SAM)***
2-Day Pass	**$375**		**Friday: Childhood Illness** **$125**
Day Pass Friday	**$275**		
Day Pass Saturday	**$275**		

TOTAL $: ______________

Mail or Fax to:

to:

Minnesota Academy of Family Physicians
600 S. Highway 169, Suite 1680
St. Louis Park, MN 55426
FAX: (952) 542-0135

Cancellation

Cancellation must be received in writing 2 weeks prior to the conference to receive a refund, minus a $50 administrative fee.

Signature: ______________________ Date: ______________