



2010 Annual Meeting Registration

2010/2011 Membership Application

June 17-19, 2010

**Jackson Lake Lodge
Jackson Hole, Wyoming**

Name: _____ Current Membership Status: _____

Department: _____

Institution: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Medical School Affiliation: _____

Current Position (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Lecturer in Human Behavior, Psychopathology, or Clerkship | <input type="checkbox"/> Asst or Assoc Director, Medical Student Education |
| <input type="checkbox"/> Clinical Attending for Psychiatry Clerkship | <input type="checkbox"/> Director, Medical Student Education |
| <input type="checkbox"/> Director or Site Coordinator, Clerkship in Psychiatry | <input type="checkbox"/> Director or Vice-Chair, Psychiatry Education |
| <input type="checkbox"/> Director, Psychopathology or equivalent course | <input type="checkbox"/> Chair, Department of Psychiatry |
| <input type="checkbox"/> Director, Human Behavior, Interviewing or equivalent course | |
| Other _____ | |

Please check if you are also currently a member of: AADPRT AAP AACDP

Annual Meeting Registration Information

	No. Attending	Subtotal
Toolbox for Early Educators workshop fee (incl. lunch and break)	_____	_____
Advance Registration Fee for Members <i>(includes all meals)</i>	_____	_____
<i>After May 14/On-site Registration Fee for Members</i>	_____	_____
Advance Registration Fee for Non-Members <i>(includes all meals)</i>	_____	_____
<i>After May 14/On-site Registration Fee for Non-Members</i>	_____	_____
House Officer/Student Registration <i>(includes all meals)</i>	_____	_____
Adult Guest Meal Plan-Option 1 <i>(includes 2 breakfasts, 1 lunch, 2 dinners)</i>	_____	_____
Children 5-11 Guest Meal Plan-Option 1	_____	_____
Adult Guest Meal Plan-Option 2 <i>(includes 2 dinners)</i>	_____	_____
Children 5-11 Guest Meal Plan-Option 2	_____	_____

Name(s) of Guest(s): _____

Please specify if you and/or guests would like vegetarian lunch/dinners. Yes No

The Chicago Medical School, Rosalind Franklin University of Medicine and Science, Office of Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Chicago Medical School will designate this educational activity for an estimated maximum of 16 credits toward the AMA Physician's Recognition Award. Each physician should claim only those hours that s/he actually spent in the activity.

Payment must accompany Registration and/or Membership

Please make check payable to ADMSEP (Tax ID 58-1365117). Submit to:
ADMSEP c/o Gary Beck
982183 Nebraska Medical Center
Omaha, NE 68198-2183
Office: (402) 559-7351 / Fax: (402) 559-5137

Refund and Cancellation Policy

Registration Fees: Requests for cancellations or substitutions must be submitted in writing to gbeck@unmc.edu. Applicable cancellation fees are as follows:

- \$50 processing fee is assessed for cancellation notices received by May 14; 50% of the registration fee is refunded for cancellation notices received between May 15 and May 22.
- No refunds are issued if cancellation is received after **May 22**. Forfeited fees may not be applied to subsequent years.

PAYMENT INFORMATION

Meeting Registration Total	_____
2009/2010 Dues-\$295.00	_____
2010/2011 Dues-\$295.00	_____
House Officer Dues-\$20.00	_____
TOTAL ENCLOSED	_____

Advanced registration and payment must be received by May 14th.