CME REGISTRATION FORM – NYU Winthrop Hospital

Name of Course: ____
Date of Course:____
Location of Course:____

PLEASE PRINT LEGIBLY OTHERWISE NO CREDIT WILL BE ISSUED!

NAME ____

TITLE ie MD, DO, RN, PA, SOCIAL WORKER _____________________________

SPECIALTY____

AFFILIATION ____

EMAIL ADDRESS (required) __________________________@_____________

Credit Card BILLING ADDRESS____

CITY/STATE/ZIP/Postal Code ____

Country____

CONTACT PHONE I (______) _______________________________________

CONTACT PHONE II (______) _______________________________________

Registration fee: USD$__________________________________ **Any Dietary Restrictions?**__________________________________

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Please FAX this completed form with ALL information, including your email address, to:

+1-516-663-9665. We will EMAIL your confirmation receipt to the address you provided.