Registration Form:

Child and Adolescent Psychiatry Practical Review – April 25-28, 2019

Participant Information (Please Print)	
Participant Name:	Title: ☐MD ☐DO ☐PA ☐NP ☐Other
Name Badge (First, Last, Title):	Specialty:
Office Name:	Office Address:
Phone:	Email Address:

A complimentary Soup and Sandwich Reception is provided for all main conference participants and family members on Thursday from 6-8 p.m.

Will you be participating? ☐Yes ☐No Will you be staying at Grand Superior Lodge? ☐Yes ☐No

Family/Guest Information

Spouse/Guest Attending? ☐Yes ☐No If yes, first & last name: _____

Will your spouse/guest be participating in the Meal Plan? ☐Yes ☐No

Children/Young Adults Attending? ☐Yes ☐No

Name	Age

Pre-Conference – April 25, 2019	All Participants $175		$
Main Conference – April 26-28, 2019	Early Bird (before 03/01/19)	Regular (after 03/01/19)	
Physicians	$600	$675	$
Non-Physicians & Residents	$450	$525	$

Family Meal Plan	# of Children	
Spouse/Guest/Children 13+ ($155 Each)	#	$
Children Ages 4-12 ($75 Each)	#	$
Children Ages 0-3 (FREE)	#	$ FREE
TOTAL AMOUNT ENCLOSED $		

REGISTRATION DEADLINE – APRIL 15, 2019. REFUNDS WILL NOT BE ISSUED AFTER THIS DATE

Payment Options:

☐ Check (Payable to St. Cloud Hospital CME)

☐ Credit Card ☐ Visa ☐ MasterCard ☐Discover ☐American Express

Card Number: _____ Expiration Date: _____

CVV Code: _____ Amount to Charge: _____

Card Holder's Name: _____

Billing Address (as appears on statement): _____

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