The Child & Adolescent
Psychiatry Practical Review

Registration Form:

THE CHILD AND ADOLESCENT PSYCHIATRY PRACTICAL REVIEW
PARTICIPANT INFORMATION:

Participant Name:

Title: ☐ MD ☐ DO ☐ PA ☐NP ☐ Other:

Name Badge (First, Last, Title):

Specialty:

Office Name:

Office Address:

City: State: Zip:

Phone: ☐ Cell ☐ Work

Email:

A complimentary Soup & Sandwich Reception is provided for
all main conference participants and family members/guests on
Thursday, April 23rd from 5:30-7:30 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: Meal Plan: ☐Yes ☐ No

Name: Age: Meal Plan: ☐Yes ☐ No

Name: Age: Meal Plan: ☐Yes ☐ No

Name: Age: Meal Plan: ☐Yes ☐ No

PRE-CONFERENCE — APRIL 23, 2026

All Participants ($300) $

MAIN CONFERENCE — April 24-26, 2026

EARLY BIRD (ON/PRIOR TO March 1, 2026)

Physicians ($725) $

Non-Physicians & Residents ($575) $

REGULAR (AFTER March 1, 2026) $

Physicians ($775) $

Non-Physicians & Residents ($625) $

FAMILY MEAL PLAN

Spouse/Guest/Children 13+ ($230 each) $

Children Ages 5-12 ($100 each) $

Children Ages 0-4 (FREE) $ FREE

TOTAL AMOUNT ENCLOSED $

REGISTRATION DEADLINE—APRIL 12, 2026
REFUNDS WILL NOT BE ISSUED AFTER THIS DATE

PAYMENT OPTIONS:

☐Check (Payable to CentraCare CME)

☐Credit Card (American Express not accepted)

☐Visa ☐ MasterCard ☐ Discover

Card Number:

Expiration Date: / CVV Code:

Cardholder's Name:

Billing Address Zip Code:

Mail to:
Medical Staff Development
St. Cloud Hospital

1406 6th Ave. N.
St. Cloud, MN 56303

Fax to:
320-255-5923

Email to:
CCMedicalStaffDevelopment@centracare.com

Questions:

320-255-5836 or CCMedicalStaffDevelopment@centracare.com