Symposium Registration Form

Please fill out form, check appropriate boxes and compute your fees. Mail form with either credit card information or check made payable to the Connecticut Academy of Family Physicians: PO Box 30, Bloomfield, CT 06002. Or, fax to: (860)-286-0787.

	Pre-Register	At Door	One Day Rate	Reception Only (This Option is available to Residents and Students ONLY)
○ CAFP/AAFP Member	$175	$225	$140	x
○ Fully-Retired CAFP Life Members	$50	$50	$50	x
○ Non-Member Physicians	$200	$250	$175	x
○ CAFP Resident	$50	$50	$50	$50
○ Student Member (*must register even though there is no charge)*	No Charge	No Charge	No Charge	No Charge
○ Guests (Non-Member Spouses, Office Staff, etc.)	$50	$50	$50	x

NOTE: One-Day Rate Only Available IF Pre-Registered by October 1, 2018.

Members Register Online at: CTAFP.org/register

○ **Wed.** ○ **Thurs.** ○ **Both** ○ **Reception Only**

Name/_____

Address

_____

_____

Email _____

Please consider an additional contribution to the Academy to help defray the cost of Student attendance.

○ $25 ○ $50 ○ $75 ○ $100 ○ Other _____

Total Registration Fee Enclosed: $_____ **Pay by Check or Credit Card**

Credit Card (Visa, MC or Amex)_____ **Exp. Date**_____

Signature_____

Please return the registration form with applicable payment to:

Connecticut Academy of Family Physicians
PO Box 30
Bloomfield, CT 06002