**CME Activity Registration**

**Please Print Clearly and Provide Legal Name**

**(Exactly as it appears on your professional license)**

|  |  |
| --- | --- |
| **Program Title:** | The CODY Conference |

|  |  |
| --- | --- |
| **Date(s) Attending:** | November 1st & 2nd , 2018 |

|  |  |
| --- | --- |
| **Location (including City and State):** | Norman Regional Hospital – Conference Center901 N Porter Ave, Norman, OK 73071 |

**Personal Data**

**NAME –** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-MAIL ADDRESS** **–** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAILING ADDRESS –** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CITY –** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE –** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ZIP –** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DAYTIME PHONE –** (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROFESSION** (CIRCLE ONE) **–**  MD DO NP PA CRNA AA RN EMT OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT** (CIRCLE ONE) **–** YES NO

**PROFESSIONAL LICENSE NUMBER(S) AND STATE(S) –** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Select TWO afternoon breakout session for November 1st (one from group A & one from group B)**

|  |
| --- |
| [ ]  **A**: Airway Management |
| [ ]  **A**: Sick and Not Sick  |
| [ ]  **B**: Case Studies in EMS/Operational Awareness |
| [ ]  **B**: Stop the Bleed |

Double click the box and change “default value” to “checked” in the menu box that appears for the one you wish to select.

**For TeamHealth Institute use only:**

CME hour(s) awarded: \_\_\_\_\_\_\_ / Nursing contact hours awarded: \_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return form to Brandi\_Idlett@teamhealth.com or fax to 405.237.7513