

Conference Instructions and Registration Fees

The Kaiser Permanente Autumn Primary Care Conference 2007 extends a warm welcome. We are pleased to offer this 3-day course at these extremely affordable rates. Your registration fee includes:

- One (1) course syllabus
- Continental breakfast with the morning sessions
- Refreshments with afternoon sessions
- Welcome Reception

For your convenience, you may register by credit card.

For online registration visit our Web site at www.kpprimarycareconference.org.

If you have any questions, you may call 510-625-6374 or e-mail primarycareconf@sbcglobal.net.

Registration Category	“Early-Bird” Rate PAY by June 29, 2007	Regular Rate PAY by Aug. 24, 2007	Late Rate PAY after Oct. 11, 2007
Permanente Physician	\$495	\$525	\$575
Non-Permanente Physician	\$650	\$700	\$750
All Health Professionals: Non-Physician	\$350	\$375	\$425
Resident	\$225	\$250	\$275

***Register online by October 11, 2007 and save up to \$50 off the registration fees listed above.**

Mail-In Registration: Please make check payable to: Kaiser Permanente Autumn Primary Care.

Mail payment and registration form to:

Primary Care 2007, 4641 Dinuba Street, Union City, CA 94587

On-Site Registration: *Advance registration closes on Oct. 11, 2007.* On-site registration will be available after October 11, 2007. We regret that we are unable to guarantee a course syllabus. An additional \$50 fee will be charged for on-site registrations. Cash, check, or credit cards are accepted for on-site registration. (A 5% service charge will apply to on-site credit card payments.)

Cancellation Policy: All cancellations must be submitted in writing, either via fax or e-mail; \$50 cancellation fee if notice is received before **Sept. 28, 2007**. Refund process can take 3–4 weeks; no refunds if notice is received after **Sept. 28, 2007**.

Please submit notice of cancellation via E-mail at primarycareconf@sbcglobal.net

October 26–28, 2007 Autumn Primary Care Conference Registration Form

NAME OF REGISTRANT (PLEASE PRINT LEGIBLY) _____

TODAY'S DATE _____

PREFERRED NICKNAME FOR BADGE _____

ADDRESS: CITY/STATE/ZIP _____

PHONE _____

PLEASE PROVIDE YOUR E-MAIL ADDRESS _____

Registration confirmation and conference information will be sent via e-mail. Use of your e-mail address will be restricted to conference staff/faculty. Please print legibly.

Please circle a region

Colorado PMG
Hawaii PMG
The Southeast PMG
Northwest PMG
Group Health Cooperative
of Puget Sound
Ohio PMG
Mid-Atlantic PMG
SCPMG
TPMG (N. Calif.)
CMI/Prog. Offices
KFH
KFHP
Other Affiliate or Network

Associate (list region) _____

Non-Permanente _____

Please circle a specialty

Internal Medicine
Acute Care/Urgent Care
Physical Therapy
Psychology/Behav. Med.
Family Practice
Preventive Medicine
Ob/Gyn
Pediatrics
Occupational Medicine
Emergency Medicine
Psychiatry
Clinical Nursing
Orthopedic Surgery
Physical Medicine
Advice Nurse

Other _____

Type of Clinician/Title (MD, NP, RN, etc.) _____

Type of practice

- Private Practice
 HMO
 Government
 Military
 Resident
 Other _____

Referred by

- Colleague
 Conference Web site/Internet
 Postcard mailing
 Brochure mailing
 Attended previously
 KP e-mail
 Other _____

Session: Your registration fee **INCLUDES** one (1) session syllabus. Please indicate your preferred (main) session. Be advised that you are welcome to attend any session/lecture that interests you regardless of the syllabus selection you make.

PC OB/G MSM **Total Tuition:** _____

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This registration form is for check payments only. To pay by credit card, please register online at www.cmxtravel.com.