REGISTRATION FORM
2019 CLINICAL VACCINOLOGY COURSE
NOVEMBER 16-17, 2019
Washington Marriott at Metro Center, Washington, DC

Please complete and return this form by email to idcourse@nfid.org

ATTENDEE INFORMATION (please print clearly or type)

First name | Middle initial | Last name | Nickname (for badge)

Professional title | Employer

Degree(s) (circle all that apply)

BA BS MA MD MPH MS NP PharmD PhD RN Other (please specify): _____

Mailing address

City | State | Postal code | Country

E-mail address | Cell phone | Work phone

❑ Yes, I would like to receive email communications from NFID.

❑ Do not include my contact information on the attendee roster.

Profession (circle one)

Nurse
Nurse Practitioner
Pharmacist
Physician
Physician Assistant
Public Health Professional
Other: _____

Primary Employment/Practice Setting (circle one)

Academia
Government
Hospital/Health System
Industry
Pharmacy
Private Practice
Public Health
Other: _____

Primary Specialty (circle all that apply)

Administration/Management
Adolescent Medicine
College Health
Epidemiology
Family Medicine
Geriatrics
Immunology
Infectious Diseases
Internal Medicine
Obstetrics/Gynecology
Pediatrics
Pediatric Infectious Disease
Pharmacy
Public Health
Research (Clinical)
Research (Non-Clinical)
Travel Medicine
Vaccinology
Veterinary
Other: _____

Continuing Education (CE) credit requested (circle one)

CME CNE Certificate of Attendance

What percentage of the work day are you involved in direct patient care? (circle one)

0% 1-25% 26-50% 51-75% 76-100%

How did you hear about this course? (circle all that apply)

CDC Colleague Emory University Facebook/LinkedIn NFID Email NFID Postcard NFID Website

Previously Attended Professional Society (please specify): _____

Other (please specify): _____

What was the major determining factor in registering for this course? (circle all that apply)

Content/Topics Continuing Education Credits Cost Location Networking Poster Presenters Speakers

Other (please specify): _____

SPECIAL NEEDS

Please email any special meeting needs, requirements, or dietary restrictions to: **idcourse@nfid.org**

EMERGENCY CONTACT _____

_____

PAYMENT (select the amount enclosed)

Early registration, including payment, must be post-marked by 9/3/19.

REGISTRATION TYPE

❑ $650 Early Registration (by 9/3/19)

❑ $750 Regular Registration (after 9/3/19)

For group registrations, please contact NFID at idcourse@nfid.org

❑ Check or money order drawn on US funds **(made payable to NFID)** enclosed in the amount of $ _____

Mail checks to: NFID, 7201 Wisconsin Avenue, Suite 750, Bethesda, MD 20814

❑ Please bill my credit card in the amount of $ _____

Select type of card ❑ Visa ❑ MasterCard

Name as printed on card

Card number

Security code | Expiration date

Signature

CANCELLATION POLICY

Refunds, less a $75 administrative fee, will be granted only if written notification is received at NFID prior to **11:59 PM ET** on **SEPTEMBER 3, 2019**. There will be no refunds for cancellations made after this date. Substitutions may be allowed; however, you must notify NFID in writing prior to **12:00 PM** on **NOVEMBER 12, 2019**. The program organizers reserve the right to cancel this course at any time. In the event of a cancellation of the course, the total registration fee paid will be refunded.

National Foundation for Infectious Diseases®

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