Expanding Your Sleep Practice Through Telemedicine

The future of healthcare has arrived. Ensure you are prepared.

REGISTRATION INFORMATION *(please type or print clearly)*

Last Name:_____ First Name: _____Degree(s): _____

Address: _____

Address Line 2: _____

City: _____State: _____Zip/Postal Code:_____ Country: _____

Phone: _____ Fax: _____

Email *(required to receive confirmation)*:_____

Special Needs/Accomodations:_____

Registration is limited to 24 attendees per course. Register Now!

3 DATES IN 2017 TO FIT YOUR SCHEDULE

(Please indicate which session you want to attend - all sessions contain the same content.)

☐ Saturday, September 28 | ☐ Saturday, October 14 | ☐ Saturday, November 4

DIETARY NEEDS

☐ Kosher ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Dairy Free

☐ Other: _____

Note: AASM cannot guarantee all requests can be met. Staff will follow up to discuss available options and instructions.

SPECIALTY *(check all that apply)*

☐ Sleep Medicine ☐ Anesthesiology ☐ Family Practice ☐ Internal Medicine

☐ Neurology ☐ Nursing ☐ Otolaryngology ☐ Pulmonary Medicine

☐ Psychiatry ☐ Psychology ☐ Pediatrics ☐ Other: _____

HOW DID YOU HEAR ABOUT THIS COURSE *(check all that apply)*

☐ Website ☐ Email ☐ Colleague ☐ Mailing ☐ Other: _____

METHOD OF PAYMENT *(check one)*

☐ Check made payable to the AASM *(U.S. funds drawn on a U.S. bank)*

☐ Credit card ☐ Visa ☐ MasterCard ☐ American Express

REGISTRATION FEE:
$299

Card #: _____

Exp. Date: _____Validation Code:_____

Cardholder's Name: _____

Billing Address: _____

Signature:_____ Date: _____

Completion includes
3 CME Credits

Questions?
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(630) 737-9770

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Mail: American Academy of Sleep Medicine
Attn: Meeting Department
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