

Conference on the Beach

29th Annual Family Medicine Update

2009 Program Registration

(Please Print Clearly)

Please indicate your status: Physician ___ ARNP ___ PA ___ Resident ___ Other *(Please Explain)* ___ Affiliated with Halifax Health? Yes ___ No ___

Please indicate if you are: Halifax Health Physician ___ or Alumnus of Halifax Health Medical Center FMRP ___

Circle One: Mr./Mrs./Ms./Dr. First Name: _____ Last Name: _____ Suffix: _____ (MD, DO, RN, PharmD, etc.)

Day Phone: (____) _____ - _____ Day Fax: (____) _____ - _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Conference on the Beach 2009 offers a maximum of 25.0 hours of AMA PRA Category 1 Credits™.

Your registration fee includes all lectures, EKG Workshop, continental breakfasts, breaks, and course syllabus on a CD copy format (printed copy available for \$25).

Additional fee is required for the hands-on Joint Injection Workshop. Limited space is available. Please see below.

3 Ways to Register: **Online:** halifaxhealth.org/cob, **Fax:** 972.506.9015, **Mail:** Resort Marketing Associates, Inc., 845 Canyon Crest, Irving, Texas 75063

For questions regarding registration, please call Resort Marketing at 972.506.9575. Checks, Visa, and Mastercard are welcome.

Make checks payable to: Conference on the Beach. Refunds may be obtained with a letter of cancellation if received prior to February 15, 2009.

A \$50.00 administrative fee will be assessed for cancellations. Program updates available on halifaxhealth.org/cob.

COB HOTEL REGISTRATION: For Hotel Reservations please contact: **The Plaza Resort & Spa**, 600 N. Atlantic Ave., Daytona Beach, FL, 32118. Call 386.255.4471 or 1.800.225.0329 or email cres@oceanresorts.com for reservation by February 21, 2009. Single or Double "Conference on the Beach" group room block \$155 (single or double). Rate does not include 12.5% state tax. No guarantee of rooms or rate after February 21, 2009 so please make reservations early.

Please notify the resort directly of any special requests (i.e. smoking, wheelchair access, etc.).

Payment Method

Please charge to: VISA MASTERCARD

Check made payable to Conference on the Beach

Account #: _____

Attendee Name: _____

Account Name: _____ Expiration Date: ___/___/___

Name on Check: _____

<u>RATES</u>	<u>IF RECEIVED BY 1-21-09</u>	<u>IF RECEIVED AFTER 1-21-09</u>	<u>AMOUNT</u>
Physician	\$575.00	\$625.00	\$ _____
Resident & Halifax Health Staff	\$475.00	\$525.00	\$ _____
Halifax Health Alumni	\$300.00	\$300.00	\$ _____

PRINTED COPY OF SYLLABUS (\$25) \$ _____

JOINT INJECTION WORKSHOP (\$50) \$ _____

TOTAL PAYMENT DUE: \$ _____

Register online at halifaxhealth.org/cob