REGISTRATION FORM

Lakewood Orthopaedics & Sports Medicine
Advanced Education Seminar
Saturday January 23, 2016 - Dallas, Texas

Use this form to register by
FAX 469-341-5677
PHONE 469-341-5676
MAIL LOSM – AES
1130 Beachview Rd., Suite 100
Dallas, TX 75218
INFO

Name

Address City State Zip

Work Phone Cell Phone

Email Fax

CHECK APPROPRIATE BOX

☐ MD ☐ DO ☐ PA ☐ NP ☐ PT

☐ EMT ☐ Coach

☐ AT TX AT Number #____________________
NATA Member #____________________
NATA Certification # ____________________

☐ AT College Student approved by curriculum director

Director____________________ NATA # _______

BADGE INFO - Name badges will be prepared from this information

Name for Badge

Institution City

EMERGENCY CONTACT INFORMATION

Contact Name

Relationship Phone

☐ Please check here if you require special assistance to fully participate. Attach a written description of needs.

For LOSM use -

The Seminar will be held in the Gymnasium on the campus of Dallas Christian College.

- Your registration confirmation will be emailed to you.

CANCELLATION AND REFUND POLICY
Refund requests must be sent in writing (dburton@losmdfw.com if by email) to Lakewood Orthopaedics & Sports Medicine within 2 weeks of the seminar and will be processed no later than 2 weeks from receipt. Refunds will be issued in the same form as the payment received.

CONTINUING EDUCATION CREDITS

Medical professionals who attend may earn up to 7 hours, or its conversion, of continuing education.
Athletic Trainers should be eligible for up to 7 CEU's.
TEA professional employees ae eligible for up to 6 Hrs. of credit depending on their teaching field.

Continuing Education Travel Seminars will handle the CEU credits. CETS is an approved provider for State of Texas TEA In-Service (CPE #902045). Credits may be possible under various organizations. Program has been submitted to Texas Athletic Trainer Advisory Board for approval.

Due to the interactive nature of this seminar, we reserve the right to limit participation to 100 attendees.

The speakers and/or subject matter may change due to circumstances beyond the control of the organizers, partners or sponsors. In an extreme case the event may have to be cancelled. We intend to honor the intent of this seminar, but sometimes life events intercede. We will do our best to preserve the seminar objectives.

Fill out these two (2) forms and mail form & payment to: **Lakewood Orthopaedics & Sports Medicine - AES**
1130 Beachview Rd. Suite 100 Dallas, TX 75218 or fax form to: **469-341-5677**.
You may also call the office at **469-341-5676** and register over the phone with your credit card.

SEMINAR REGISTRATION	**Advance Registration**	**On-Site Registration**		**FEE**
Physicians	$45	$45		$
Other medical professionals (ex: AT, PT, PA, NP, etc.)	$45	$45		$
All others (ex: coaches, public, etc.) attending full day	$45	$45		$
All others only attending the afternoon concussion session (no meals provided)	$20	$20		$
College Student	$20	$20		$
College student must be a junior or senior AT student and registered by their curriculum director.				
COACHING / AT STAFF REGISTRATION				
(You MUST register with one payment and list members individually) (Person in charge of the group should make sure all forms are completed and submit the group together. We must have page 1 of this form for each individual.)				
Staff of 3 to 5 members	$35 each	$35 each		$
Staff of 6 to10 members	$30 each	$30 each		$
Staff of 11 to 15 members	$25 each	$25 each		$
Staff of 16+ members	Call for pricing	N/A		$
WEBINAR (all individuals)	$55	N/A		$
Institutional Viewing (call for organizing instructions)	$55 base fee + $20 each			$
CEU credit will be issued only for time actually logged in. This is a BOC Category A event and does not require a separate post-test. [YOU MUST REGISTER BY 9AM ON JANUARY 20.]				
TOTAL DUE				$

If mailing form and paying by check, please make payable to: Lakewood Orthopaedics & Sports Medicine.

PAYMENT INFORMATION

First Name ______________________________

Last Name ______________________________

Billing Address ______________________________

City ____________________

State_______ Zip _________

Credit / Debit Card Type: [ ] Credit Card #: [ ]

Person's Name on Card: [ ] Expiration Date: [ ]

CVV2 Number: [ ] (Required for Visa, MasterCard, & Discover)

Signature: ______________________________