



Registration Form

Registration Deadline Date:

December 5, 2001

Fax Number: 314-894-6506

ATTN: Cheri Phillips

This form must be completed and returned prior to the Deadline Date in order to be considered for attendance at this program

Program No.: 02.ST.HCV.C.A Dates: January 16-18, 2002

Title of Program: New Strategies for the Treatment and Supportive Care of Veterans with Hepatitis C

Location of Program: Hilton San Francisco & Towers, 333 O Farrell Street, San Francisco, CA

PARTICIPANT INFORMATION (Please type or print)

Name: (First, MI, Last)

Highest Professional Degree: (i.e., M.D., Ph.D., R.N.)

Alternate Name Badge

If the name and/or location on your name badge should be different, please indicate below:

First & Last Name:

City & State:

SSN:

Sex: Male Female

Job Title:

Occupational Category: Administrative Associated Health Physician Dentist Nurse

Employer Category: VHA VBA National Cemetery Other Federal Non-Federal

Accreditation/Approval Requested: ACCME ANCC SW ACPE APA Generic

Phone: x FAX: x

For VA Employees

Facility (Name/Number):

Address:

City / State / Zip:

Service/Dept. Name: Mail Routing Symbol:

For Non-VA Attendees

Company Name:

Address:

City / State / Zip:

Alternate Mailing Address

If an address is different from that above needs to be used for mailing purposes, please indicate below:

(continued on reverse)

Program No.: 02.ST.HCV.C.A

Participant s Name: _____

While at program, name & number to call in event of an emergency:

_____ X _____

If you require special arrangements due to physical limitation(s), please describe:

Please indicate if you have any special dietary needs: _____

TRAVEL INFORMATION *(if applicable)*

Authorized Travel Dates _____ *travel to program* _____ *return home*

AUTHORIZATION TO PARTICIPATE

Immediate Supervisor: _____
Signature _____ *Date* _____

_____ *Name, Title* _____ *Phone* _____

Service Chief or
Next Higher Level Supervisor:

_____ *Signature* _____ *Date* _____

_____ *Name, Title* _____ *Phone* _____