Name: ___________________________________  Degree: ☐ MD  ☐ DO  ☐ NP  ☐ Resident  ☐ Other: ____________

Daytime Phone: ___________________________  Email: ________________________________

Address: ____________________________________________________________________________

City: ________________________________________  State: __________  Zip: ________________

Do you have any special requirements?  ☐ Yes  ☐ No  If yes, explain: ________________________________

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**REGISTRATION FEES**

(On or Before 5/14/15)  (After 5/14/15)

☐ $425 Physicians  ☐ $450 Physicians

☐ $275 Advanced Practice Nurses  ☐ $300 Advanced Practice Nurses

☐ $225 Resident Physicians with letter of verification  ☐ $35 Printed syllabus. Pre-order your copy by May 29, 2015.

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Registration fee includes three continental breakfasts, two buffet lunches, refreshment breaks and a CD containing the conference handouts.

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**LUNCHEON SEMINARS AND WORKSHOPS**

You will attend one Seminar on Friday and one Workshop on Saturday. Register early to receive your preferences. Seminars/workshops are on a first-come, first-serve basis. Indicate three preferences:

**Friday Luncheon Seminars** (Check agenda for expanded workshop title descriptions)

___ F1 Topic: Superbugs: Antibiotic-resistant Pathogens in Outpatient Pediatrics

___ F2 Topic: Pediatric Puzzlers

___ F3 Topic: Pediatric Radiology Workshop

___ F4 Topic: Pediatric Nephrology Potpourri

___ F5 Topic: Pediatric Pulmonary Potpourri

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**Saturday Luncheon Workshops** (Check agenda for expanded workshop title descriptions)

___ S1 Topic: Pediatric Dermatology in the Emergency Department: When to Worry and When to Not

___ S2 Topic: Visual Diagnosis Part 13: Unusual Infections

___ S3 Topic: Red Flags in Development

___ S4 Topic: Pediatric Cardiology Potpourri

___ S5 Topic: Pediatric Hematology/Oncology Potpourri

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**TWO EASY WAYS TO REGISTER**


2. **Mail:** Return your completed registration form and payment to:
   
   UTHSCSA-CME
   
   7703 Floyd Curl Drive, MC 7980
   
   San Antonio, TX 78229-3900

   ☐ Check enclosed (Payable to UTHSCSA CME - 156267)

   ☐ Please charge my:  ☐ VISA  ☐ MasterCard  ☐ Discover  ☐ American Express

   Card Holder Name: ___________________________________________  Card Number: ________________________________

   Signature: ________________________________________________  Exp. Date: ______/_________

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If you must cancel, the registration fee will be refunded less a $50 handling charge if notice is received by May 14, 2015. Cancellations received after May 14, 2015 will not be refunded. Confirmation: All early registrations are confirmed in writing. If you do not receive a confirmation, call (210) 567-4491 or 1-888-601-4448, or email cme@uthscsa.edu.