ACNP 2006 NATIONAL CLINICAL CONFERENCE

Speaker Registration Form October 11-15, 2006 Orlando, FL

*Register by **9/8/06** to receive your badge in the mail.*

Please use the address at which you would like to receive registration correspondence. Please print clearly as illegible forms will be returned. On-line registration available at www.acnpconference.com

First Name _____ Middle Initial _____

Last Name _____

Credentials _____

Workplace _____

Address is for: ☐ Home ☐ Business

Address _____

_____

City _____ State/Province _____

Country _____ ZIP/Postal Code _____

Daytime Phone _____

Phone _____ Fax _____

E-mail

SS# (To receive CE Credits) _____

State License # _____ In The State of _____

ATTENDEE DEMOGRAPHIC INFORMATION

1. Specialty

- ❑ ANP
- ❑ WHNP
- ❑ Psych/Mental Health NP
- ❑ PNP
- ❑ GNP
- ❑ CNM
- ❑ ACNP
- ❑ FNP
- ❑ RN
- ❑ PA
- ❑ Other (Specify) _____

2. Practice Setting (Check all that apply)

- ❑ College Health
- ❑ Psych/Mental Health center
- ❑ Community Health Center
- ❑ Correctional Facility
- ❑ Rural Health clinic
- ❑ Military
- ❑ Home Health Agency
- ❑ State Institution
- ❑ Nursing Home
- ❑ HMO/PPO
- ❑ Women's Health Center
- ❑ Planned Parenthood
- ❑ Hospital (in-Patient)
- ❑ Internist
- ❑ Public Health Clinic
- ❑ MD/NP
- ❑ Emergency Room
- ❑ School
- ❑ NP Owned Practice
- ❑ Homeless Shelter
- ❑ Teen Center
- ❑ Occupational Health
- ❑ Hospital (Ambulatory)
- ❑ Other (Specify)

3. Do you have prescriptive authority? ☐ Yes ☐ No

4. Subspecialty Areas (check all that apply)

- ❑ Acute Care
- ❑ Bioethics
- ❑ Dermatology
- ❑ Emerging Infectious Diseases
- ❑ Gastrointestinal
- ❑ Hematology
- ❑ Oncology
- ❑ Pediatrics
- ❑ Practice Management
- ❑ Reproductive
- ❑ Sexually Transmitted Infections
- ❑ Cardiovascular
- ❑ Diabetes
- ❑ Endocrine
- ❑ Geriatrics
- ❑ Neurological
- ❑ Pain Management
- ❑ Pharmacology
- ❑ Mental Health
- ❑ Pulmonary
- ❑ Symptom Management
- ❑ Women's Health
- ❑ Technology
- ❑ Adult Health

ADA Information. Registrants requiring special needs or assistance, please indicate special need here:

_____.

CHANGE/CANCELLATION POLICY

All changes and cancellations must be submitted in writing by September 8, 2006, to qualify for a refund less a $50 processing fee. No refunds will be issued after September 8, 2006. Refunds will be processed based on the original form of payment within 60 days after close of the meeting. No-shows will be charged the full registration fee. Refunds or overpayments in the amount of $50 or less will not be refunded.

Registration Fees

Please indicate the day(s) of your presentation ☐ **10/12** ☐ **10/13** ☐ **10/14** ☐ **10/15**

Full Registration (FULL)

- ❑ Member $420
- ❑ Non Member** $495

Speaker Full Registration Discount

Number of Days Presenting _____ X **$185** = (Credit) _____

Fee _____

Daily Registration*

☐ **Thursday** (THU) ☐ **Friday** (FRI) ☐ **Saturday** (SAT)

Member (per day) $185

Non- Member (per day) $210

Fee _____

❑ **Additional Saturday Event Ticket** $50

Fee _____

Workshops ($150 workshops require full or daily registration)

☐ **W1 $225 Fundamental Critical Care Course (Full Registration Required for FCC course)**

☐ **W2 $150** ☐ **W3 $150** ☐ **W4 $150** ☐ **W5 $150** ☐ **W6 $150**

☐ **W7 $150** ☐ **W8 $150** ☐ **W9 $150**

Workshop Fee _____

Registration Total _____

****Includes 1 year of ACNP membership and subscription to the Journal for Nurse Practitioners.**

***Includes access to all events (except Workshops) and 1 gala ticket.**

Session Selection (List session number for each selection).

Thursday, 10/12/06	1st choice	Alternate
10:45am - 11:45am		
2:00pm - 3:00pm		
3:15pm - 4:15pm		
4:30pm - 5:30pm		
Friday, 10/13/06		
9:00am - 10:00am		
2:45pm - 3:45pm		
4:00pm - 5:00pm		
5:15pm - 6:15pm		
Saturday, 10/14/06		
10:30am - 11:30am		
1:15pm - 2:15pm		
2:30pm - 3:30pm		
3:45pm - 4:45pm		
Sunday, 10/15/06		
7:30am - 8:30am		
8:45am - 9:45am		
10:00am - 11:00am		

PAYMENT INFORMATION

❑ Enclosed check or money order for $ _____

(Please make payable to the ACNP National Clinical Conference)

CREDIT CARD PAYMENTS

❑ American Express ❑ MasterCard ❑ VISA

Credit Card Number _____

Expiration Date _____

Cardholder Name(Please print) _____

Cardholder Signature _____

SUBMIT INDIVIDUAL REGISTRATION FORM TO:

ACNP Registration Center
c/o J. Spargo & Associates, Inc.
11208 Waples Mill Road, Suite 112
Fairfax, VA 22030
Fax: 703-631-1673

QUESTIONS

Phone: 888-243-7419
Email: acnpregistration@jspargo.com