

REGISTRATION FORM

Register Online at
www.pedsEMcourse.com



MASTERING PEDIATRIC EMERGENCIES

FROM NEWBORN TO ADOLESCENCE

Fax Your Form To:
(888) 329-8626

or Mail Completed Form To:
The Center for Medical Education, Inc.
P.O. Box 600
Creamery, PA 19430 USA

Tuition

	Full Tuition	Early Bird Tuition
Physician for MD, DO, MBBS, etc.	\$795	\$745
Resident, PA, NP, RN, etc.* and other members of the medical team	\$695	\$645

*For residents, a letter verifying residency status by the departmental chair or program director must accompany your registration to receive the discounted tuition. We require nurses, NPs and PAs to provide a copy of their license to receive the discounted tuition.

Early Bird Tuition: Register by July 31, 2023 to receive the early bird pricing.

Early Bird Discount

Save \$50 when you register at least 6 weeks before the live course.

For groups attending the *Mastering Pediatric Emergencies Conference*, please call our office at 1-800-458-4779 for special pricing.

Registration/Refund Cancellation Policy: Cancellations must be made to the Center for Medical Education via phone (800-458-4779), fax (610-454-9494) or email (support@ccme.org) prior to the start of the conference and will be charged a \$35 cancellation fee. **No refunds** will be given on or after the start date.

Registrant Information

First Name _____ Last Name _____

Home Address _____

City _____ State/Province _____

Zip/Postal Code _____ Country _____

Email _____

Home Phone _____ Work Phone _____

Title (Check one): Physician - MD Physician - DO Physician Assistant - PA Nurse Practitioner - NP Registered Nurse - RN

Resident - MD Resident - DO

Course Dates & Location

September 12–14, 2023
Las Vegas, Nevada

Early Bird Discount: Register by July 31, 2023 to receive early bird tuition

Caesars Palace

3570 Las Vegas Blvd South, Las Vegas, NV 89109

Billing Information

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____ CVV# Three-digits on the back of Visa or MasterCard.
Four-digits on the front of American Express Cards.

First Name of Authorized Cardholder _____

Last Name of Authorized Cardholder _____

Billing Address _____

Billing City _____ Billing State/Province _____ Billing Zip/Postal Code _____

Billing Country _____ Billing Email _____

Visa MasterCard

American Express

Check # _____

Made payable to "Center for Medical Education" in U.S. funds