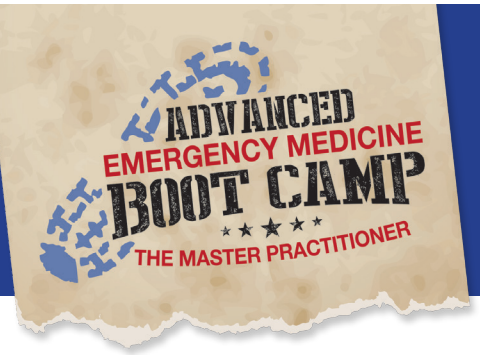
REGISTRATION FORM

www.EMBootCamp2.com

To obtain more information or to register by phone, simply call (800) 458-4779
(9:00am-4:30pm ET, M-F)



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

or Fax Your Form To:
(888) 329-8626

Main Course Pricing

	Full Tuition	Early Bird Tuition
PAs / NPs / RNs / Residents	**$695**	**$645***
Physicians	**$795**	**$745***

***Early Bird Rate Tuition Deadline:** August 8, 2019 by 9 PM PT.

Workshop Pricing (Optional Add-Ons)

	Tuition
ECG Boot Camp	**$145***
Imaging Boot Camp	**$145***

*Must attend the main course to add a workshop

BUNDLE & SAVE: Register for both workshops and receive the 2nd for only $115 (a $30 savings!).

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 & Workshop Options

Advanced EM Boot Camp – Main Course

September 20-22, 2019 (3 Days)
Bally's Hotel & Casino / Las Vegas, NV

Half-Day Workshops (Optional Add-Ons)

Yes! Register me for the below workshops on September 19, 2019.
(Check all that apply)

☐ **ECG Boot Camp**
(8:00am-12:15pm)

☐ **Imaging Boot Camp**
(1:30pm-6:00pm)

Discounted Room Rate
A block of rooms has been reserved at the discounted rate of **$79/night (9/18-9/19) + $160/night (9/20-9/21) + resort fee (optional at check-in) + tax** at Bally's Hotel & Casino in Las Vegas, Nevada. Call the Bally's Las Vegas reservationist at (800) 358-8777 and mention that you are attending the *Advanced Emergency Medicine Boot Camp Course* under the "Passkey" system to receive the room block rate. Group code: SBEMB9.

Reserve a room before **August 19, 2019** to receive the discounted rate. Once the block is full, this reduced rate will no longer apply, regardless of the cut-off date.

Billing Information

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____ CVV# ☐☐☐ (Last 3 numbers on back of Visa and MasterCards)

First Name of Authorized Cardholder _____

Last Name of Authorized Cardholder _____

☐ Visa ☐ MasterCard

☐ Check # _____
Made payable to "Center for Medical Education" in U.S. funds

Billing Address _____

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

Billing Country _____ Billing Email _____