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Videoconferenced Regularly Scheduled Series REGISTRATION FORM

Course Objective(s):

At the completion of this program the participant should be able to :

1.

Date viewed event: _____

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If you are a UC Davis Affiliate: (CHECK ONE)

- FACULTY
- CLINICAL FACULTY
- PCN FACULTY
- VOLUNTEER FACULTY
- SOM ALUMNI
- OTHER _____

OCCUPATION:

- NP RN MSW LCSW
- TECH CRNA OPTOMETRIST
- PA RD Other _____

MD or DO need specialty

Specialty : _____

Medical Student Resident Fellow

NAME: _____ Last 4 digits of your SSN#:xxx-xx-_____ (For transcript purposes)

MAILING ADDRESS: _____ (address you would like us to mail your complimentary annual transcript)

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