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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: \_\_\_\_\_

Accessed using \_\_\_\_\_ Computer \_\_\_\_\_ Telemedicine Equipment

Provider \_\_\_\_\_ UCD/CME \_\_\_\_\_ UCTV \_\_\_\_\_ Other \_\_\_\_\_

Organization: UCSF UCDHS KAISER OTHER \_\_\_\_\_

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)

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Email address: \_\_\_\_\_

### Mail or fax REGISTRATION FORM and EVALUATION to:

**Gwenn Welsch - Distance Education** Phone (916) 734-5773 Fax (916) 734-0776  
**Continuing Medical Education**  
**3560 Business Drive, Suite 130, Sacramento, CA 95820**

### CONFIDENTIALITY STATEMENT

I understand and agree that I shall respect and maintain the confidentiality of all discussions, deliberations, records, and any other information generated in connection with these activities by the medical staff, departments, divisions, or their committees. I shall make no voluntary disclosures of such discussion, deliberations, records, and information except to persons authorized to receive it in the conduct of medical staff affairs.

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