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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: \_\_\_\_\_

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Mail or fax **REGISTRATION FORM** and **EVALUATION** to:  
**Gwenn Welsch - Distance Education** Phone (916) 734-5773 Fax (916) 734-0776  
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### CONFIDENTIALITY STATEMENT

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