

Register Online: Register online at www.primarychildrens.org/transport

Online pre-registration closes **Wednesday, February 8, 2012.**

Early Bird Discount: Register by **January 7, 2012** (postmarked)
Registration is limited for the Bronchotron Survivor Workshop and Simulation Lab.

Cancellation Policy: Written notice is required to receive a refund. All refunds are subject to a \$50 processing fee. No refunds will be made after **January 21, 2012.**

Mail and Fax Registration Due By: **Monday, February 6, 2012** (postmarked)

Mail:

Pediatric Education Services
Primary Children's Medical Center
675 East 500 South, Suite 100
Salt Lake City, Utah 84102

Questions, contact Jill Burton:

Phone: 801.662.3502 or 800.910.7262
Fax: 801.662.3522
Email: Jill.Burton@imail.org

Name (please print) _____

MD Mid Level Provider RN Other (Specify) _____

RT, please write in AARC member #: _____

Hospital/Program _____

Address _____

City _____ State _____ Zip _____

Daytime Phone _____

E-mail (Confidential – used for conference only) _____

Please indicate any special needs _____

Question for presenter(s)? _____

Tuition:

	Early Bird Fee postmarked by 1.07.12	Regular Fee After 1.07.12	
Main Conference For RNs, RTs, and others:	\$395	\$445	_____
For mid-level providers, and physicians:	\$495	\$545	_____
One Day Conference Fee			
<input type="checkbox"/> Tuesday or <input type="checkbox"/> Wednesday	\$250	\$275	_____
Optional Lab Day (2.13.12) Seating is limited.			
Bronchotron® I Workshop	\$150	\$175	_____
Simulation Lab			
<input type="checkbox"/> Session 1 or <input type="checkbox"/> Session 2	\$160	\$185	_____
Will you attend the Tuesday evening bash?			<input type="checkbox"/> Yes <input type="checkbox"/> No
UNA Members receive a \$25 discount with membership number: # _____			
		Total	_____

Please select which breakout sessions you would like to attend.

Tuesday, 2.14.12 Neo: 1 2 3 Wednesday, 2.15.12 Neo: 1 2 3
 Peds: 1 2 3 Peds: 1 2 3

Payment:

Payment must accompany registration. No purchase orders accepted.

- Check (Make payable to Pediatric Education Services)
- MasterCard Visa Discover American Express

Authorized Cardholder _____

Account Number _____

Exp. Date _____

Authorized Signature _____



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