

TELEMERGENCY TRAINING PROGRAM REGISTRATION FORM



Name/Title _____

Address 1 _____

Address 2 _____

City/State/Zip _____

Phone _____ FAX _____

Email _____

Method of Payment Check Visa MasterCard

Credit Card # _____

Three Digit Security Code (on back) _____

Exp. Date _____ Zip code _____

Name as it appears on card _____

Signature _____

Area of Interest

Clinical _____

Administrative _____

Technical _____

Other _____

Registration Fee: 165 per person; group discount available.

Print this page and FAX or mail completed registration form to:

Buanita Benson
University of Mississippi Medical Center
Department of Emergency Medicine
TelEmergency Program
2500 North State Street
Jackson, MS 39216
FAX: 601-815-3487