REGISTRATION FORM

STFM Conference on Practice & Quality Improvement

September 11–13, 2023
St Louis, MO

Name (for badge): _____ Degree(s): _____

Institution: _____

Address: _____

City, State, Zip: _____

Phone (cell/home/work): _____ Fax: _____

Email: _____

Our official conference partners will receive a set of mailing labels, including all conference attendees for a one-time-use mailing; content to be preapproved by STFM.

Demographics:

Date of Birth: ___/___/___

What is your current gender identity? (Select all that apply)
☐ Male/Man ☐ Female/Woman ☐ Genderqueer/Gender non-conforming ☐ Non-binary ☐ Prefer to self-describe
☐ Choose not to disclose

Which of the following best defines your race or ethnicity? (Select all that apply)
☐ Hispanic/Latino/of Spanish Origin ☐ American Indian/Alaska Native/Indigenous ☐ Asian ☐ Black/African American
☐ Native Hawaiian/other Pacific Islander ☐ White ☐ Middle Eastern/North African ☐ Choose not to disclose

One of both my parents (or whoever raised me) graduated from college: ☐ Yes ☐ No ☐ Choose not to disclose

Underrepresented in medicine means those racial and ethnic populations that are under-represented in the medical profession relative to their numbers in the general population (Black/African-American, Hispanic/Latino/of Spanish Origin, American Indian/Alaska Native/Indigenous, Native Hawaiian/other Pacific Islander, and certain Asian ethnicities*).
** Vietnam, Cambodia, Indonesia, and Laos*

I self-identify as underrepresented in medicine: ☐ Yes ☐ No

Professional Role: *check all that apply*

☐ Administrator/Manager ☐ Behavioral/Social Science Specialist ☐ CEO/Executive Director ☐ Chair/Vice Chair
☐ Chief Medical Officer ☐ Coordinator ☐ Dean/Associate or Assistant Dean ☐ DIO ☐ Fellow ☐ Fellowship Director
☐ Health Educator/Dietician ☐ Medical Assistant ☐ Medical Director ☐ Medical School Faculty ☐ MSE/Clerkship Director
☐ Nurse ☐ Nurse Practitioner ☐ Pharmacist ☐ Physician Assistant ☐ Practicing Physician ☐ QI Specialist ☐ Researcher
☐ Residency Director/Associate Director ☐ Residency Faculty ☐ Resident ☐ Retired ☐ Student

Additional Information:

First-time Attendee: ☐ Yes ☐ No

Dietary Restrictions: ☐ None ☐ Vegetarian ☐ Vegan ☐ Gluten-free

I am requesting special ADA accommodations to fully participate in the conference: ☐ Yes ☐ No

Special Accommodations: _____

Emergency Contact Name: _____ Phone: _____

CONFERENCE ATTENDEE COVID-19 VACCINATION ATTESTATION

The Society of Teachers of Family Medicine (STFM) has implemented enhanced health and safety measures in connection with its 2023 conferences. In addition, STFM requires all attendees, exhibitors/partners, and staff to be fully vaccinated against COVID-19 before attending. While vaccinations, observance of safety protocols, and exercise of personal discipline may reduce risk, an inherent risk of exposure to COVID-19 does remain in connection with any public gathering. See our complete policy at: *stfm.org/media/3932/stfm-health-and-safety-policy-for-conference-and-event-attendeesmay22.pdf*

Accordingly, as a condition of your attendance at this event, please click the box below to indicate your acknowledgement of, and agreement to the following:

It is understood that COVID-19 is an extremely contagious disease that can lead to severe illness and death. I acknowledge my desire and voluntary choice to travel to and participate in this STFM conference and/or event. I assume responsibility and accept the risk of being exposed, contracting, and/or spreading COVID-19 to attend the STFM conference and/or event. Specifically, I assume all risks and accept sole responsibility for any injury (including, but not limited to, personal injury, illness, disability, and death) that I may experience in connection with attendance, and hereby waive, release, and hold harmless STFM, and its employees, agents, contractors, and representatives from any claims, liabilities, actions, damages, losses, costs, or expenses of any kind arising out of or relating to my attendance. I agree to follow all instructions and safety precautions posted or provided by STFM, the conference and/or event venue, and/or any governing authority during conference and/or event attendance (eg. wearing masks in all meeting areas). It is understood and agreed that my failure to do so may result in being excluded from the event without refund, reimbursement, or other renumeration.

☐ I have read and agree with the STFM COVID-19 policy related to conference and event attendance and attest that I am fully vaccinated against COVID-19.

☐ I am requesting a COVID-19 exemption for religious or medical reasons.

Name:_____ Date:_____

REGISTRATION FEES

The conference registration fee includes participation for all sessions. All registration fees are in US dollars. Register online at stfm.org/cpqi

	By August 11	After August 11
☐ Practicing or faculty physician	$520	$620
☐ Other educator/clinician/administrator/staff	$445	$545
☐ Team Member (each)*	$345	$445
☐ Resident or Student	$345	$445
☐ One Day Registration	$275	$375

**3 or more from same practice or residency; does not include physicians or residents*

PRE-CONFERENCE WORKSHOPS *(Optional; Additional fees apply):*

Participants must pre-register.

Monday, September 11; 8:30 am–12:30 pm

☐ **PR01: Using Relational Leadership and Psychological Safety to Teach and Implement Team-Based Quality Improvement**
Fee: $150; includes training materials, CME, and light refreshment. Attendance limit: 30

☐ **PR02: Solve Your Problems Permanently With Quality Improvement That Works**
Fee: $150; includes training materials, CME, and light refreshments. Attendance limit: 30

POST-CONFERENCE WORKSHOP *(Optional; Additional fees apply):*

Participants must pre-register.

Wednesday, September 13; 1–5:30 pm and Thursday, September 14; 8 am–12:30 pm
(Note: participants must attend both ½ day sessions)

☐ **PR03: Point of Care Ultrasound Workshop**
Fee: $500; includes training materials, CME, and light refreshment. Attendance limit: 36

PAYMENT INFORMATION

Total Amount Enclosed: $_____ *Total Registration Fee + Other Optional Fees*

Method of Payment:

☐ Check Enclosed, Payable to STFM ☐ American Express ☐ Discover ☐ Mastercard ☐ Visa

Card Number: _____CVV: _____Expiration Date: _____

Name on Card: _____

Billing Address: _____

Refund Policy: If a registrant cannot attend a conference for personal or work reasons, requests for refunds must be received in writing by STFM by August 11, 2023 to receive a 50% registration fee refund. No refunds will be issued after August 11, 2023 except for those emergencies addressed below:

Refund requests due to medical or weather emergencies at time of conference may be eligible for a 50% refund. If a registrant is unable to attend because of a weather emergency, the registrant must show that they attempted to reschedule their travel arrangements but could not get to the conference during the official conference dates. In the event of such cancellation request by a conference registrant, the registrant must provide STFM with official documentation to support their request. In the unlikely and extreme event that STFM is forced to cancel a conference, STFM is not responsible for fees or penalties that conference registrants may incur for non-refundable airline tickets or hotel deposits.

STFM Conference Covid-19 Refund Policy: If an attendee needs to cancel due to COVID-19 on or before September 10, 2023, the attendee will need to provide STFM with a formal request in writing with positive test results from a physician; STFM will provide a full conference refund. There are no refunds issued after September 10, 2023.

How to Register:
Mail this form with payment to:
STFM
11400 Tomahawk Creek Parkway, Suite 240
Leawood, KS 66211-2672

Or, fax this form with credit card information to (913) 906-6096

Or, Email with credit card information to *stfmoffice@stfm.org*