

Tropical Medicine Course

REGISTRATION

Email: _____

First Name: _____ Middle Name: _____

Last Name: _____

Job Title: _____

Company/Organization: _____

Address Line 1: _____

Address Line 2: _____

City: _____ US State/Canadian Province: _____

Zip (Postal Code): _____

Work Phone: _____ Fax: _____

Please select (with an "X") your registration level:

<input type="checkbox"/>	Course only \$500	<input type="checkbox"/>	Course with Labs \$650
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*Continuing Medical Education as been applied for via the AAFP (American Academy of Family Practitioners)

Make checks out to the 'University of Colorado Center for Global Health' (in memo line put Tropical Medicine Course)

Checks and registration form must be mailed to:

N Michelle Shiver

Center for Global Health

University of Colorado Denver

Mail Stop F496

12631 E 17th Avenue, Rm 3506

Aurora, CO 80045