



Society Of Correctional Physicians Spring Conference

# BRIDGING

## Mental Health and Primary Care

### New Perspectives on Fundamental Problems

**April 21, 2013 | Denver, CO**

Print your name as you wish it to appear on your badge and other correspondence.

Name: \_\_\_\_\_ Degree(s) \_\_\_\_\_

Job Title: \_\_\_\_\_ Place of Work: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

**Membership Fees** Please  begin /  renew my membership in the Society of Correctional Physicians

Physicians.....\$150       Physician Assistants and Nurse Practitioners.....\$100

**Meeting Fees**

**Thru 3/31**

**After 3/31 & Onsite**

SCP Member..... \$150      \$195

Nonmembers..... \$200      \$245

**Total Enclosed:** \_\_\_\_\_

**Payment Information**

Enclosed is my check made payable to the Society of Correctional Physicians (SCP).

Please bill my  MasterCard       Visa       American Express       Discover

Card #: \_\_\_\_\_ Expires: \_\_\_\_\_

Signature (for credit card payment only): \_\_\_\_\_

Billing Address (if different than above): \_\_\_\_\_

**For New and Renewing Members**

By my signature, I attest that I am a doctor of medicine or osteopathy who holds a license to practice medicine by an appropriate board of licensure that does not limit my practice solely to the correctional setting or I am a Physician Assistant or Nurse Practitioner, and am engaged in the practice, teaching or research of correctional medicine. I certify that my renewal application as submitted is true and correct. I agree to comply with SCP's bylaws and code of ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return this registration form, along with payment, to:**

Society of Correctional Physicians

1145 W. Diversey Pkwy.

Chicago, IL 60614

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