Society of Correctional Physicians

SPRING Educational Conference

April 6, 2014 | Atlanta, Georgia

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: _____

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

☐ Physicians.....$150 ☐ Physician Assistants, Nurse Practitioners, and Dentists.....$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, osteopathy, or dentistry 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:

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Chicago, IL 60614
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