

Trauma & Critical Care Series (TRA-CCS) Participant Registration

Participant Information:

Name and title: _____

Institution: _____

Mailing information for contact hours certificate:

Address: _____

City, State, Zip: _____

The address above is my (check one): home address work address

E-mail: _____ Phone _____

Please register me for (check desired option):

_____ The entire TRA-CCS 2010 monthly series

_____ Specific TRA-CCS session (indicate dates): _____

I will participate by (check desired option):

_____ **Attending in person.**

A confirmation and map will be sent to you prior to the conference.

Contact hours will be mailed to you upon return of the evaluation.

_____ **Watching via web live or within 2 weeks of the session(s).**

You will be e-mailed an access password and an evaluation.

Contact hours will be mailed to you upon return of the evaluation.

_____ **Contact me regarding purchase of a CD of archived sessions.**

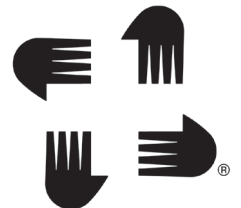
Available on a quarterly basis at a cost of \$15.

Includes video of lecture, objectives and evaluation for individual or institutional use.

Contact hours not available from HCMC, but educators may use materials to set up credits within your individual institution.

Provide the following information by fax, e-mail, or mail.

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MC O-9 Trauma Services
701 Park Avenue South
Minneapolis, MN 55415



Hennepin County
Medical Center

Questions? Contact Karie Pearce at 612-873-3449 or karie.pearce@hcmcd.org.