



QUALITY SHARING DAY

VA COOPERATIVE STUDIES PROGRAM CLINICAL RESEARCH PHARMACY REGISTRATION FORM

Individual Information

Date _____

Name:

Request Name for Badge:

Organization:

Are you a VA employee? Yes No

Address:

City: _____ State: _____ Zip: _____

Work Phone (_____) _____ Cell Phone (_____) _____

The best time to contact me is: _____ A.M. P.M. on my Work phone Cell phone

E-Mail Address:

Would you like to receive our e-newsletter? Yes No

Session Selection

- June 24
 July 13
 October 5

All sessions are \$395. including lunch and materials, and run from 8:00 – 5:00 pm.

Please specify if you require special accommodations:

Do you have any food allergies/requirements:

Payment Information

Credit Card #:

Expiration Date:

Master Card Visa American Express

Cardholder Name:

Cardholder Address:

City: _____ State: _____ Zip: _____

Work Phone:

Your card will be charged for \$395.00.

Cancellation Policy: If cancellation is received via e-mail or Fax seven (7) days prior to the start of the conference, the registration fee less a \$35. Administrative fee will be refunded. No refunds will be made after this deadline. If the VA cancels the scheduled session, all tuition fees will be refunded.

Please fax this completed form to (505) 256-5467 or email to brinm@brinm.org