C.A.P.E.S. Program for Primary Care Physicians

Program Registration Form

Name_____Credential_____

Business Name_____

Mailing Address_____

City_____ State _____ Zip Code _____

Phone Number_____

Fax Number_____

Email_____

Agency Website Address_____

Are you a member with the American Academy of Pediatricians? ___Yes ___No

Are you a member with the American Academy of Family Practitioners? ___Yes ___No

Would you be interested in accessing live training events from your office via the internet? ___Yes ___No

If yes, do you have the computer capability to view web-streamed activities? ___Yes ___No

Do you have access to teleconferencing equipment? ___Yes ___No

How would you prefer to receive C.A.P.E.S. Program information/updates? (Please check all that apply)

___ Print Mailings ___Email ___Program Website ___Fax

Which C.A.P.E.S. Program Services are you most interested in? (Please check all that apply)

___ Telephone Consultation ___ Education Events ___ Outpatient Referral Services

Please fax this form to 518-583-2265.

or mail to Michele Phillips, Four Winds Hospital, 30 Crescent Avenue, Saratoga Springs, NY 12866.