NAPCRG
Practice-Based Research Network Conference

PBRN Conference
Reston, VA
June 17 - June 18, 2024

MEETING REGISTRATION FORM

(*Fields with asterisk are required)

*Name_____Credentials_____

*Name to appear on badge_____

Organization_____

*Address _____

*City_____Prov/State_____*Country_____PC/Zip_____

Phone_____ *E-mail _____

TELL US ABOUT YOURSELF

***Date of Birth:**_____/_____/_____

***Gender Identity (Select all that apply):**

- O Female/Woman
- O Genderqueer/Gender non-conforming
- O Prefer to self-describe
- O Male/Man
- O Non-binary
- O Choose to Not Describe

***Race or Ethnicity (Which of the following best defines your race or ethnicity? Select all that apply):**

- O American Indian/Alaskan Native/Indigenous
- O Black/African American
- O Middle Eastern/North African
- O White
- O Asian
- O Hispanic/Latino/Of Spanish Origin
- O Native Hawaiian/Other Pacific Islander
- O Choose to Not Describe

***There is also a definition of underrepresented in medicine:**

Underrepresented in medicine (URM) means those racial and ethnic populations that are underrepresented in the medical professional relative to their numbers in the general population (Black/African American, Hispanic/Latino/of Spanish Origin, American Indian/Alaska Native/Indigenous, Native Hawaiian/other Pacific Islander, and certain Asian ethnicities*)

*Vietnam, Cambodia, Indonesia, and Laos

I self-identify as URM: O **Yes** O **No**

***PBRN Role:**

- O Network Director or Associate Director
- O Network Manager/Administrator
- O Coordinator/Facilitator
- O PBRN Collaborator/Researcher
- O Medical Student
- O Project Officer
- O Patient/Community Member
- O Other_____

***Discipline:**

- O Family Medicine
- O Nursing
- O Public Health/Community Health
- O Dentistry
- O Psychology/Psychiatry/Behavioral Sciences
- O Other_____
- O Internal Medicine
- O Pediatrics
- O Pharmacy
- O Research/Health Services Research
- O Healthcare Administration

*Are you a first-time attendee? O Yes O No

I am requesting special ADA Accommodations to fully participate in the conference. O Yes O No
Special Accommodations:

_____

_____

_____

*Do you have any special dietary needs?
O None
O Gluten free
O Vegan
O Vegetarian
O Other_____

*I acknowledge that by attending PBRN I may be photographed or recorded during conference proceedings and these media may be used for future NAPCRG promotional purposes. O Yes

Attendee name and contact information will be shared with other NAPCRG attendees at this event. Please check the box below If you'd like to opt out of having your information shared.
O Opt Out of Sharing

VOLUNTEER OPPORTUNITIES

*Would you like to moderate a session during the meeting? O Yes O No

*Would you like to lead a poster walk during a session during the meeting? O Yes O No

*Would you like to lead a roundtable discussion during the meeting? O Yes O No

2024 REGISTRATION RATES

	Early Bird Rate (through May 16)	Regular Rate (May 17 and after)
NAPCRG Member	$350	$460
Non-Member	$400	$510
Patient	$85	$105

All registration fees are in USD

NAPCRG Health and Safety Policy for Conferences, Events, and Meetings

To attend the NAPCRG Annual Meeting and/or any related meetings or events you acknowledge that an inherent risk of exposure to CoVID-19 exists in any public place where people are present.

By participating you voluntarily assume all risks related to exposure to CoVID-19 and agree not to hold NAPCRG or any of their affiliates, directors, officers, employees, agents, contractors, exhibitors, sponsors or volunteers liable for any illness, injury, disability or Public Health restrictions including, but not limited to mandatory quarantine requirements. Moreover, you also agree to follow all local and property specific protocols such as, but not limited to, capacity limits, screening, masking, physical distancing and collection of contact information where required.

Click here to view the full policy.

O *I have read the North American Primary Care Research Group's COVID-19 acknowledgement and agree to above statement

PAYMENT INFORMATION

O American Express O Discover Card O MasterCard O Visa O Check *(Make check or money order payable to NAPCRG)*

Card Number_____

Exp Date_____ CCV_____ Total Fees: $ _____

Cardholder_____

Signature: _____

Billing Address _____

(Tax ID #51-0239450)

CANCELLATION/REFUND POLICY

All Requests for refunds must be received in writing. Written requests received by NAPCRG on or before May 16, 2024, will receive a 50% refund. No refunds will be issued on or after May 17, 2024.

HOW TO REGISTER

Online: www.napcrg.org
By Mail: 11400 Tomahawk Creek Pkwy, Suite 240, Leawood, KS 66211
Questions? napcrgoffice@napcrg.org

Funding for this conference was made possible [in part] by grant (1R13HS029438-02) from the Agency for Healthcare Research and Quality (AHRQ). The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.