

HIV 101

An Introduction to Treatment for the HIV Positive Client



February 17, 2012

UMMC Conference Center

\$50.00 course fee (lunch included)



PURPOSE/GOAL(S): The purpose of this course is to increase awareness and offer a beginner level training to RNs, LPNS, SWs and case managers who may be new to the field of treating HIV/AIDS. The presentations strive to increase understanding and awareness of HIV/AIDS, including information on prevention, adherence and disease epidemiology.

REGISTRATION/SIGN-IN begins promptly at 7:45 a.m., course ends at 4:30 p.m.

Nurses (MNF)

The University of Mississippi School of Nursing Continuing Education Program is an approved provider of continuing nursing education by the Mississippi Nurses Foundation, Inc. an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

As an approved provider, the University of Mississippi School of Nursing designates this offering as meeting the criteria for 7.25 contact hours.

Social Work (NASW)

The University of Mississippi Medical Center is approved as a provider of Social Work Continuing Education credits by the National Association of Social Workers, Mississippi Chapter, call back after January 15 to verify social work credit.

For more information call 601-984-5542

CANCELTION POLICY: Cancellations may be made in writing, up to 5 days prior to the program without forfeiture of fee, and mailed to UMMC Continuing Education at the address below, Attn: Joan Bounds.

HOW TO REGISTER:

By Mail to UMMC Continuing Education, 2500 North State Street, Jackson, MS 39216-4505

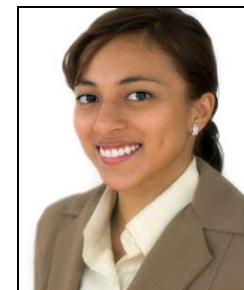
By FAX to 601/984-1309; must include VISA® or MASTERCARD® information, card expiration date, purchase order number, or alternate payment information; *registrations without payment information cannot be accepted.*

By UMMC Employee Payroll Deduction-I authorize UMMC payroll deduction for the total registration fee of \$50.00 from my next payroll period. I understand I am responsible for this amount should I terminate from UMMC employment or have insufficient future net pay to cover this outstanding balance.

PLEASE NOTE: Registration fees are applied to program costs, resources, and meals.

UMMC Employee # _____ Employee/Cardholder Signature: _____

Print full name of employee or cardholder: _____



REGISTRATION FORM
HIV 101
UMMC Conference Center, Jackson Medical Mall
(February 17, 2012)

For program listings, visit our website at <http://conted.UMC.edu> or call (601) 984-1300.

In accordance with ADA, check here if you require special accommodations. Someone from our office will contact you.

Are you a UMMC Employee Yes - UMMC ID Number _____ No

PLEASE TYPE OR PRINT CLEARLY COMPLETING ALL AREAS ON THIS FORM.

Name _____ Degree (s) _____
(Last) (First) (Middle Initial)

Preferred Mailing Address: Home Business

Street/P. O. Box _____ Apt. No. _____

City _____ State _____ Zip Code _____

E-mail address _____
(For registration confirmation and notification of future training programs.)

Social Security Number (**last 4 digits**) _____

Hospital or Organization (employer): _____

Daytime Telephone No. () _____ Fax () _____

Please check your professional category:

RN LPN NP Case Manager Social Worker (List License Number) _____

Special Area of Practice: _____

Fee: \$50.00 No Fee: Student (Accepted on space available basis) **Pre-registration is required.**

CANCELLATION POLICY: Written cancellations, to address below, are accepted up to 5 days prior to program without fee forfeiture. **NO SHOWS:** Fees are forfeited.

Enclosed is my check or money order for \$ _____ made payable to: **UMMC Continuing Health Professional Education.**

Please charge \$50.00 to my Visa® or MasterCard® Expiration Date: _____

Card No. _____ 3 Digit Security Code _____

UMMC Employee Payroll Deduction: I authorize UMMC payroll deduction for the total registration fee of \$50.00 from my next payroll period. I understand I am responsible for this amount should I terminate from UMMC employment or have insufficient future net pay to cover this outstanding balance.

UMMC Employee number _____ Employee/Cardholder Signature: _____

Printed full name of employee or cardholder: _____

Return check and completed form or photocopy to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216-4505. Telephone (601) 984-1300, Telefax (601) 984-1309. FAXES not accepted without full payment information.