



The Academy of Medicine of New Jersey Roving Symposium Registration Form

Hospital/Agency _____

Mailing Address _____

Director of Medical Education or Person Responsible for CME: _____

In my absence please contact _____

Telephone _____ FAX _____

Topic Selection (Each Selection Must Have a Separate Form): _____

Date (Month/Day/Year): _____ Time _____ AM PM

Symposium Location _____

Moderator _____

Hospital Title/Position of Moderator _____

Justification for Roving Symposium Selections

Needs Assessment: Please identify the process used to determine your institution's need for the topic. Each selection must have a separate form.

- Request by staff physician, facility, department head, or planning committee.
- Survey of medical staff by survey questionnaire.
- Review of evaluation forms from previous programs.
- Data obtained from hospital audits, quality management, risk management, infection control or other staff committee. Identify Committee _____
- Other (Please identify): _____

Objectives: Upon completion of this symposium, participants should be able to:

1. _____
2. _____
3. _____

Mail completed Application with Registration Fee
made payable in US Dollars to:

Academy of Medicine of New Jersey
Attn: Coleen Hampson
Two Princess Road, Suite 101
Lawrenceville, NJ 08648

Registration Fee: \$500.00 – AMNJ Institutional Members
\$600.00 – Non-Member Organizations