

# TRAINING REGISTRATION FORM

for your convenience this form  
may be completed online at  
<http://cta-training.com>



Course Name: \_\_\_\_\_ Course Date \_\_\_\_\_

Section I:	Contact Information	Date _____
Name: _____	E-mail: _____	
Address: _____	City: _____	State: _____ Zip _____
Phone (_____) _____	Work Phone (_____) _____	Cell Phone (_____) _____
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. on my <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone		
Practice Name: _____	Administrative Contact: _____	
Office Address: _____	City: _____	State: _____ Zip _____
Office Phone (_____) _____	Fax (_____) _____	Admin E-mail: _____

Section II	Professional Information
Which of the following best describes your practice? <input type="checkbox"/> Private <input type="checkbox"/> Academic <input type="checkbox"/> Other: _____	
How many physicians are in your practice? _____	
Name and address of your primary hospital? Name: _____	
Address: _____ City: _____ State: _____ Zip _____	
Please list the states in which you are licensed to practice _____	
How familiar are you with coding, billing and medical documentation for coronary CTA? <input type="checkbox"/> Very familiar <input type="checkbox"/> somewhat familiar <input type="checkbox"/> Not familiar	
How did you learn about this course? _____	
Please briefly describe your level of previous training and experience in both CT imaging and cardiac imaging in general _____	
Please briefly describe what you consider would make this course a success for you personally _____	
Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section III	Payment Preference
Please refer to the course information you received or our website for course pricing. <b>Fees are payable upon registration</b> via Credit Card, Electronic Check or paper Check in the mail. Please indicate your preference:	
<input type="checkbox"/> <b>Credit cards</b> are accepted <a href="#">online</a> via PayPal to <a href="mailto:jradamsmd@gmail.com">jradamsmd@gmail.com</a> or by phone to Hilary Faverman, Administrative Assistant at (415) 691-6096	
<input type="checkbox"/> <b>Electronic Checks</b> are accepted <a href="#">online</a> via PayPal to <a href="mailto:jradamsmd@gmail.com">jradamsmd@gmail.com</a>	
<input type="checkbox"/> <b>Checks</b> should be made payable to <b>CVIC Associates, Inc</b> and mailed to:  James Adams, MD CVIC Associates, Inc. 5 Bon Air Road, Suite 108 Larkspur, CA, 94939	
<b>Don't forget to submit this form</b> to Fax 360-361-1380, scan/e-mail, or mail to the above address. Thank You!	