

REGISTRATION FORM

STFM Conference on Medical Student Education

January 30-February 2, 2025

San Antonio, TX

INFORMATION

Name: _____ Degree(s): _____

Institution: _____

Address: _____

City, State, Zip: _____

Phone (cell/home/work): _____ Fax: _____

Email: _____

Our official conference partners will receive a set of mailing labels, including all conference attendees for a one-time-use mailing; content to be pre approved by STFM.

Demographics:

Date of Birth: ____/____/____

What is your current gender identity? (Select all that apply)

- ☐ Male/Man ☐ Female/Woman ☐ Genderqueer/Gender non-conforming ☐ Non-binary
☐ Prefer to self-describe ☐ Choose not to disclose

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

- ☐ Hispanic/Latino/a/Spanish Origin ☐ American Indian/Alaska Native/Indigenous ☐ Asian
☐ Black/African American ☐ Native Hawaiian/other Pacific Islander ☐ White
☐ Middle Eastern/North African ☐ Choose not to disclose

One of both my parents (or whoever raised me) graduated from college: ☐ Yes ☐ No

☐ Choose not to disclose

Underrepresented in medicine means those racial and ethnic populations that are under-represented in the medical profession 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 underrepresented in medicine: ☐ Yes ☐ No

Professional Role: *check all that apply*

- ☐ Administrator/Manager ☐ Behavioral/Social Science Specialist ☐ CEO/Executive Director
☐ Chief Medical Officer ☐ Coordinator ☐ Dean ☐ Dean-Assistant/Associate ☐ Department Chair
☐ Department Vice Chair ☐ DIO ☐ Faculty-Medical School ☐ Faculty-Residency Program ☐ Fellow
☐ Fellowship Director ☐ Health Educator/Dietician ☐ Medical Assistant ☐ Medical Director
☐ MSE/Clerkship Director ☐ Nurse ☐ Nurse Practitioner ☐ Pharmacist ☐ Physician Assistant
☐ Practicing Physician ☐ Program Director ☐ Program Director-Assistant/Associate ☐ QI Specialist
☐ Researcher ☐ Resident ☐ Retired ☐ Student

Additional Information:

First-time Attendee: ☐ Yes ☐ No

Dietary Restrictions: ☐ None ☐ Vegetarian ☐ Vegan ☐ Gluten-free

I am requesting special ADA accommodations to fully participate in the conference: ☐ Yes ☐ No

Special Accommodations: _____

Emergency Contact Name: _____ Phone: _____

Health and Safety Policy: stfm.org/about/governance/statements/#43882

☐ I have read and agree to the terms of STFM's health and safety policy.

STFM Ethics and Conduct Policy: stfm.org/about/governance/statements/#35832

☐ I have read and agree to the terms of STFM's ethics and conduct policy.

REGISTRATION FEES

The conference registration fee includes participation for all sessions. All registration fees are in US dollars. Register online at stfm.org/mse

	By Dec. 29, 2024	After Dec. 29, 2024 & On-site
<input type="checkbox"/> Member	\$505	\$605
<input type="checkbox"/> NonMember*	\$900	\$1000
<input type="checkbox"/> Fellow	\$295	\$395
<input type="checkbox"/> Resident	\$255	\$355
<input type="checkbox"/> Student	\$170	\$270
<input type="checkbox"/> Coordinator/Administrator**	\$295	\$395
<input type="checkbox"/> One Day	\$295	\$395
<input type="checkbox"/> Community Preceptor***	\$295	\$395

**This fee includes STFM membership for either active physician or active other family medicine educator membership categories.*

***Non-physician health professional, coordinator, and/or administrative staff.*

**** Teacher who practices off-campus and who does not have a primary appointment in a department/medical school.*

PRE-CONFERENCE WORKSHOPS *(Optional; Additional fees apply):*
Participants must pre-register.

Thursday, January 30, 1–5 PM

- ☐ **PR01:** Empowering Family Medicine Educators with AI tools
Fee: \$150; includes light refreshments and CME.

Limit: 50 participants

- ☐ **PR02:** FMIG Faculty Advisor and Supporter Workshop
No Fee: Sponsored by the American Academy of Family Physicians

Limit: 50 participants

PAYMENT INFORMATION

Total Amount Enclosed: _____ *Total Registration Fee + Other Optional Fees*

Method of Payment:

☐ Check Enclosed, Payable to STFM ☐ Mastercard ☐ Visa ☐ AMEX

Card Number: _____ CVV: _____ Expiration Date: _____

Country: _____ Zip Code: _____

Refund Policy: If a registrant cannot attend a conference for personal or work reasons, requests for refunds must be received in writing by STFM by December 29, 2024 to receive a 50% registration fee refund. No refunds will be issued after December 29, 2024 except for those emergencies addressed below:

Refund requests due to medical or weather emergencies at time of conference may be eligible for a 50% refund. If a registrant is unable to attend because of a weather emergency, the registrant must show that they attempted to reschedule their travel arrangements but could not get to the conference during the official conference dates. In the event of such cancellation request by a conference registrant, the registrant must provide STFM with official documentation to support their request. In the unlikely and extreme event that STFM is forced to cancel a conference, STFM is not responsible for fees or penalties that conference registrants may incur for non-refundable airline tickets or hotel deposits.

Mail this form with payment to:

STFM
11400 Tomahawk Creek Parkway, Suite 240
Leawood, KS 66211-2672

Or, fax this form with credit card information to (913) 906-6096

Or, email with credit card information to stfmoffice@stfm.org