MUSC
Fall Imaging Practicum
October 4, 2025

By Registering for this conference, you acknowledge and agree to the cancellation policy stated below.

Name _____ Personal ID# XXX - XX - _____
(As you would like it printed on your name badge) *(Last four digits of your SSN)*

Address _____

City _____ State _____ Zip _____

Specialty _____ Degree/Credentials _____

Email _____
(Please provide your active email address to ensure proper receipt of all CME Credit documentation.)

Phone (_____) _____ - _____ Fax (_____) _____ - _____

PLEASE READ THE STATEMENTS BELOW AND CHECK THE BOX IF YOU AGREE.

☐ YES I give permission to the MUSC Office of CME to share my name, city, and state with other attendees and the companies that will be exhibiting at and/or supporting the conference through educational grants.

☐ NO I do not give permission to the MUSC Office of CME to share my name, city, and state with other attendees and the companies that will be exhibiting at and/or supporting the conference through educational grants.

PLEASE SELECT THE APPROPRIATE RATE(S)

Physician in Practice/Practicing Faculty ☐ Complimentary

Non-Physician/Resident ☐ Complimentary

Complimentary In-Person Registration form for MUSC Fall Imaging Practicum
for MUSC Physicians in Practice/Practicing Faculty and MUSC Non-Physicians/Non-faculty

Form must be completed and returned to CME Office no later than
September 4, 2025

Completed Registration form should be emailed to:
cmeoffice@musc.edu