

REGISTRATION FORM

Introduction to Clinical Quality Improvement

ATTENDEE INFORMATION (please complete each field)

Full Name (including credentials): _____
Name you prefer using (nametag): _____
Administrative position / Medical specialty: _____
Organization/Facility/Department: _____
Mailing Address: _____
City: _____ Zip: _____
Phone: _____ E-Mail: _____

Contact at your office (assistant):

Contact Name: _____
Phone: _____
E-Mail: _____

(In order for you to receive information regarding the program for which you are registering, we need to have an e-mail address.)

- | | | |
|--------------------------|---|------------------------------|
| <input type="checkbox"/> | September 26 & 27, 2013
(Thursday – Friday)
8:30 a.m. – 5:00 p.m. | Clinical Quality Improvement |
| <input type="checkbox"/> | November 7 & 8, 2013
(Thursday – Friday)
8:30 a.m. – 5:00 p.m. | Clinical Quality Improvement |

**These courses will be presented at
Intermountain Healthcare Corporate
Offices - Capitol View Rooms
36 South State Street, 16th Floor
Salt Lake City, Utah 84111**

Please return your registration form to:
Intermountain Healthcare
Institute for Health Care Delivery Research
36 South State Street, 16th Floor
Salt Lake City, Utah 84111
Voice: (801) 442-3030 Fax: (801) 442-3486
E-mail: Stefanie.bowen@imail.org

Website: www.intermountainhealthcare.org/about/quality/institute

For travel arrangements

Please contact Intermountain Travel Services for assistance and negotiated hotel rates. **(800) 442-2018.**