



ORTHOPAEDIC SECTION, APTA, INC.

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Individual Residency Curriculum Offering Verification Form

Residency Program: _____

Address: _____

Program Director/Coordinator: _____

Phone Number: _____ E-mail: _____

Program Credentialed? Yes No

Program Developing? Yes No

If developing, anticipated date of application submission (Month/Year): _____

Start/end date of program (month/year): _____

DIRECTOR/COORDINATOR (NOTE: Directors/Coordinators must be Orthopaedic Section Members to register for the curriculum package)

Name: _____

APTA #: _____ E-mail Address: _____

Mailing Address: _____

As Director/Coordinator I would like to receive the following course(s): _____

RESIDENT 1 (NOTE: Residents must be Orthopaedic Section Members to register for the curriculum package)

Name: _____

APTA #: _____ E-mail address: _____

Mailing Address: _____

RESIDENT 2 (NOTE: Residents must be Orthopaedic Section Members to register for the curriculum package)

Name: _____

APTA #: _____ E-mail address: _____

Mailing Address: _____

COURSE TITLE: _____

Resident Fees: ♦3-monograph course: \$45 ♦6-monograph course: \$90 ♦12-monograph course: \$140
\$10.00 shipping and handling per course

Credentialed Programs: Please submit the following information with this form in order to process your Individual Residency Curriculum Offering Verification Form.

- Resident Contract/Appointment Letter

PAYMENT INFO:

- Check enclosed (Payable to Orthopaedic Section, APTA)
- Credit card: MasterCard, Discover, American Express, Visa (circle one)

Credit card #: _____

Expiration date: _____

Signature of cardholder: _____

Print name of cardholder: _____

Billing address for credit card: _____

Registration fee: _____

Shipping and handling: _____

Membership fee: _____

TOTAL: _____