Presenter Form

You must enter this information online in order to receive credit.
http://www.msafp.org/register_tarwars.asp

Presenter’s Name: ________________________________

Date of Presentation: ______________________________

Profession of Presenter:

☐ Classroom Teacher  ☐ Nurse  ☐ Dentist
☐ Physician Assistant  ☐ Health Educator  ☐ Respiratory Therapist
☐ Family Physician  ☐ Resident  ☐ Medical Student
☐ Nursing Student  ☐ Other (please specify)________________________

Presenter’s Email address: ________________________________

Elementary School’s Name: ________________________________

Teacher’s Name: ________________________________

Teacher’s Email Address: ________________________________

School’s Mailing Address: ________________________________

City, State, Zip: ________________________________

School’s Phone: ________________________ County of School: ________________________

# of 4th grade students: ____________  # of 5th grade students: ____________

Comments ________________________________

____________________________________

MISSISSIPPI ACADEMY OF
FAMILY PHYSICIANS
FOUNDATION

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