POSTER PRESENTATION APPLICATION FORM

The application form must be completed and submitted to the PR AFP via email to **info@amfpr.org** by **March 15, 2017.** A short abstract of the poster must accompany the application, to be submitted in English, must not exceed 200 words and must be in *.txt, .doc* or *.docx* format if submitted as an attachment. Authors are responsible for complying with the poster presentation guidelines upon abstract submission. Incomplete applications will not be considered.

I. Poster title:

_____
_____

II. Poster category (check one)

____ Research ____ Clinical Inquiry

III. Author(s)

Author #1
First Name: _____ Last Name: _____
Author designation: ___ PI ___Co-PI ___ Collaborator

Category:
___ Family Physician (Graduated Settings): ___ Clinical ___ Academic ___ Research
___ PYG1 ___ PYG2 ___ PYG3 ___ PYG4 (Family Medicine Residents)
___ MS1 ___ MS2 ___ MS3 ___ MS4 (Medical Students)

Author #2
First Name: _____ Last Name: _____
Author designation: ___ PI ___Co-PI ___ Collaborator

Category:
___ Family Physician (Graduated Settings): ___ Clinical ___ Academic ___ Research
___ PYG1 ___ PYG2 ___ PYG3 ___ PYG4 (Family Medicine Residents)
___ MS1 ___ MS2 ___ MS3 ___ MS4 (Medical Students)

Author #3
First Name: _____ Last Name: _____
Author designation: ___ PI ___Co-PI ___ Collaborator

Category:
___ Family Physician (Graduated Settings): ___ Clinical ___ Academic ___ Research
___ PYG1 ___ PYG2 ___ PYG3 ___ PYG4 (Family Medicine Residents)
___ MS1 ___ MS2 ___ MS3 ___ MS4 (Medical Students)

Author #4
First Name: _____ Last Name: _____
Author designation: ___ PI ___Co-PI ___ Collaborator

Category:
___ Family Physician (Graduated Settings): ___ Clinical ___ Academic ___ Research
___ PYG1 ___ PYG2 ___ PYG3 ___ PYG4 (Family Medicine Residents)
___ MS1 ___ MS2 ___ MS3 ___ MS4 (Medical Students)

IV. Contact information

Please provide the key contact information requested. All main communications will be directed to this contact.
First Name: _____ Last Name: _____
Street Address: _____
City: _____ State: _____ Zip Code_____
Email Address: _____
Residency Program /Medical School (if applies): _____

V. IRB information (if applicable)

Is the project IRB-approved?
___ YES (please attach documentation)
___ NO

If no, please explain:
_____
_____
_____
_____
_____