

Save the Date

29th Annual Maternal Child Nursing Symposium

Friday, October 12, 2018 8:00 am – 3:45pm

Wesley Medical Center - Cessna Conference Center

Providing Culturally Competent Care to Transgender Patients

Medical Transition for Transgender Adolescents and Young Adults

Sarah Pilcher, MSN, RN, CPNP

Boston Children's Hospital, Boston Massachusetts

Cardiac Disease in Pregnancy and the Association with Pre-eclampsia

Karen Florio, DO, MS

St. Luke's Hospital, Kansas City, Missouri

Anatomy of a Medical Malpractice Claim – A Focus on Maternal – Fetal Medicine

Don Gribble II, Esq.

Hite, Fanning & Honey L.L.P, Wichita, KS

A Review of Surfactant Delivery Methods

Dave Hampton, RRT, MSED

ONY/Infasurf, Buffalo, New York

Register online at www.wichitamedicalresearch.org and receive a \$5 discount. Online registration will close at noon on October 5th, 2018. For mailed registrations see next page.

\$60 if postmarked on or before September 28, 2018

\$70 if postmarked on or before October 5, 2018

\$80 Walk in registration (*accepted based on availability of space*)

Credit: 7.5 contact hours for nursing, and Respiratory Care; 6.25 contact hours for EMS

The Wichita Medical Research & Education Foundation has contracted with Wesley Medical Center as an approved provider of CNE by the Kansas State Board of Nursing. This symposium is approved for 7.5 contact hours applicable for RN and LPN relicensure, Kansas State Board of Nursing provider # LT 0085-0327.



29th Annual Maternal Child Nursing Symposium

Mail-in Registration Form

(Use this form only for mail or faxed registrations)

Name _____

Address _____

City _____ State _____ Zip _____ Day Telephone _____

Email _____

Hospital/Institution Name/City _____

WMC Employee 3/4ID _____ Non WMC Employee last 4 of SSN # _____

License # _____

Classification: __APRN __RN __LPN __RCP __EMS __Other _____

Payment must accompany registration. Fee includes lunch and breaks.

___ \$60 if postmarked on or before September 28, 2018

___ \$70 if postmarked after October 5, 2018

___ \$80 Walk-in registration *(accepted based on availability of space)*

___ Check enclosed for amount of \$ _____ payable to WMREF

___ Bill my credit card for the amount of \$ _____

___ Visa ___ MasterCard ___ Discover # _____

Exp. Date _____ Signature _____

Complete this form and return with payment to:

Wichita Medical Research & Education Foundation

3306 E Central

Wichita, KS 67208

Or fax to 316.687.0033 *(faxes must include credit card payment information)*