



Fill out the form below, indicating your name and hospital affiliation, as you would like it to appear on your official name badge. You will receive a return confirmation via e-mail on receipt of this your transmission, but please note that your registration is not guaranteed until we have received your payment. You will receive a final confirmation notice at that time. \*Indicates those items that must be filled out.

\*First Name \_\_\_\_\_

\*Middle Initial \_\_\_\_\_

\*Last Name \_\_\_\_\_

Title (MD, RN, RRT, other): \_\_\_\_\_

\*Hospital \_\_\_\_\_

\*Hospital Address \_\_\_\_\_  
\_\_\_\_\_

\*City \_\_\_\_\_

\*State/Province \_\_\_\_\_

\*Zip/Postal Code \_\_\_\_\_

\*Country \_\_\_\_\_

\*Phone (work) \_\_\_\_\_ Fax \_\_\_\_\_

*Note: Please include Country and City Code*

E-mail \_\_\_\_\_

**Preferred Mailing Address (if different from above):** *same as above address*

Address \_\_\_\_\_

Address2 \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_ Zip/Code \_\_\_\_\_ Country \_\_\_\_\_

**\*See NEXT PAGE for Payment Information**

We accept VISA, Mastercard, American Express, or checks

Physician –	\$640.00	<input type="checkbox"/>
*Non – Physicians –	\$550.00	<input type="checkbox"/>
Continuing Medical Education Credit Hours	\$40.00	<input type="checkbox"/>
Banquet – Thursday Night, If Registered	NC	<input type="checkbox"/>
Banquet – Thursday Night, If Guest	\$50.00 each	Number of Guest _____
	guest	

*\*Non – Physician category includes: Nurses, Fellows, Residents, Respiratory Therapists, Clinical Perfusionists, Nurse Practitioners*

**\*\*Additional \$50.00 will be added to registration fee after February 1st**

Registration Fee	\$
Banquet Fee	\$
Continuing Medical Education Hours (CEU, CME, etc.) Fee	\$
Total Fee	\$

*Please indicate if you will be paying by:*

Check

\*Credit Card

*\*Please fill out CC form and FAX to 202-476-3459, Attention: Robin Muir, RN, Conference Coordinator*

***Make Check Payable to: CNMC ECMO Conference***

***Mail Registration Form with Check or Credit Card Form to:***

*Dr. Billie Lou Short*

*Division of Neonatology*

*CNMC*

*111 Michigan Ave, NW*

*Washington, DC 20010*

## ***Cancellation Policy***

**Refunds will be made only for written cancellations received prior to February 1<sup>st</sup>, 2010. A \$75.00 administrative fee is charged on all refunds.**

**Children's National Medical Center  
ECMO Training Course**

**Credit Card Form**

Name as listed on credit card: \_\_\_\_\_

Amount to be Charged: \_\_\_\_\_

Credit card type: VISA  Mastercard  American Express

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Mailing Address for the Cardholder:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Return completed form to:*

Billie Lou Short, MD  
CNMC  
Division of Neonatology  
111 Michigan Ave., NW  
Washington, DC 20010

Form may be faxed to 202/476-3459 Attention: Robin Muir