REGISTRATION FORM

In order to complete the registration process, kindly complete and submit the form below. **All fields are required.**

First/Given Name: _____ Last/Family Name: _____
Institution: _____
Address: _____
City: _____ State: _____ Zip: _____ Country: _____
Phone: _____ Fax: _____
E-mail (required to receive confirmation): _____
Assistant Email: _____

Please select a registration type:

- ☐ AATS Member
- ☐ Physician
- ☐ Resident/Fellow/Medical Student
- ☐ Allied Health Professional
- ☐ Non-Exhibiting Industry

AMERICAN ASSOCIATION FOR THORACIC SURGERY
Focus on Thoracic Surgery: Lung and Esophageal Cancer
500 Cummings Center, Suite 4550, Beverly, MA 01915
P: 978-927-8330 | F: 978-524-0461 | meetings@aats.org