REGISTRATION FORM

Advancing the Cardiovascular Care of the Oncology Patient
January 25-27, 2019; Washington, D.C.

Please use **ONE of these methods** to register; (do not mail if previously faxed, telephoned or registered online)
1. **Mail** completed form and payment to: American College of Cardiology; Attn: Resource Center P.O. Box 37561, Baltimore, MD 21279-3561
2. **Fax** the registration form to: 202-375-7000
3. **Call** 800-253-4636, ext. 5603, or (Outside the U.S and Canada, 202-375-6000, ext. 5603)
4. **Visit** ***ACC.org/cvoncology*** to register online

Membership Number (If applicable)

Last Name *(Please print clearly)* **First Name** **Middle Initial**

☐ **MD** ☐ **DO** ☐ **PhD** ☐ **RN** ☐ **NP** ☐ **PA** ☐ **CNS** ☐ **Other** _____

Street Address

City **State** **Zip**

Office Phone **Office Fax** **Email** ***(Please print clearly)***

Practice Administrator's Name **Phone**

What is your primary medical area of interest: (Check one)

☐ Adult Cardiology ☐ CV Surgery ☐ Family/General ☐ Internal Medicine ☐ IV Cardiology ☐ Ped. Cardiology □ Radiology □ Other _____

REGISTRATION TUITION

Please register me as:	**Designation**	**Early Before 10/15/18**	**Regular 10/16/18 – 12/21/18**	**Onsite 12/22/18 – 1/27/19**
Member Physician (includes International Associate)	MD, DO, PhD	□ $550	□ $650	□ $750
Non-member Physician	MD, DO, PhD	□ $775	□ $875	□ $975
Member Reduced (Includes CCA Members, CVT, FIT, Resident, Student and Emeritus)	PA, RN, NP, CNS, PharmD, FIT, Emeritus, Resident, Student	□ $350	□ $450	□ $550
Non-member Reduced	PA, RN, NP, CNS, PharmD	□ $450	□ $550	□ $650
Industry Professional		□ $825	□ $950	□ $1,050

Proof of licensure required for PA, Tech, RN, CNS and NP (non-CCA members); letter from training director needed for FIT
International registrants are urged to FAX application to the ACC.

Payment must accompany application.

☐ Check payable to: American College of Cardiology, in US dollars drawn on a US bank

☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

_____ _____
Cardholder's Name (Please print clearly) Signature

_____
Card Number Expiration Date Security Code

☐ **Special Needs** (Please advise us of your needs)

_____
Special Dietary Requirements: (Advance notification required)

☐ Vegetarian ☐ Other _____ (Please Specify) ACC staff will contact you to verify if this Special Meal Request can be accommodated

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