REGISTRATION FORM

REGISTER ONLINE AT www.cme.hsc.usf.edu/letournel2010
REGISTER BY FAX: (813) 974-3217
RETURN REGISTRATION FORM AND PAYMENT TO:
UNIVERSITY OF SOUTH FLORIDA HEALTH
PROFESSIONS CONFERENCE CORPORATION (HPCC)
PO BOX 864240, ORLANDO, FL 32886-4240

A CONFIRMATION LETTER WILL BE SENT UPON RECEIPT OF YOUR REGISTRATION AND PAYMENT (NO REGISTRATION IS CONFIRMED WITHOUT FULL PAYMENT)

NAME

TITLE (MD, RN, ETC.) SPECIALTY

GENDER:
☐ MALE ☐ FEMALE

ADDRESS

CITY

STATE ZIP

COUNTY

☐ PHYSICIAN ☐ FELLOW

☐ STRYKER CORPORATE ☐ STRYKER REPRESENTATIVE
NAME OF PHYSICIAN/FELLOW THAT YOU ARE ATTENDING THE CONFERENCE WITH

DAYTIME PHONE

FAX NUMBER

EMAIL ADDRESS

REGISTRATION FEES

REGISTRATIONS ARE ACCEPTED ON A FIRST COME FIRST SERVE BASIS AS SPACE IS LIMITED. REGISTRATION IS FOR PHYSICIANS AND FELLOWS ONLY

PHYSICIANS/FELLOWS..............................................$1,750.00 (U.S. DOLLARS)

GUEST FEE FOR WELCOME RECEPTION............$45.00 (U.S. DOLLARS)

STRYKER CORPORATE/REPRESENTATIVES..$350.00 (U.S. DOLLARS)

I WILL
☐ ATTEND THE WELCOME RECEPTION
☐ NOT ATTEND THE WELCOME RECEPTION
☐ BRING A GUEST (S) TO THE WELCOME RECEPTION

MAIL TO ADDRESS LISTED ABOVE.

ENCLOSED IS MY CHECK MADE PAYABLE TO: USF HPCC IN THE AMOUNT OF $______

CREDIT CARD: ☐ VISA ☐ MASTERCARD ☐ AMEX

IN THE AMOUNT OF $________

CARD NUMBER

SECURITY CODE/CCV

(AMEX-4 digits on front, MC/Visa-3 digits on back)

EXP. DATE

NAME ON CARD (PRINT)

SIGNATURE

PN2011302/1170