Clinical Osteoporosis 2010: An ISCD-NOF Symposium
Registration Form

(Please Print Clearly)

Registrant Information

❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr. ❑ Other_____

First/Given Name Last/Family Name

Badge Name Designation/Degree

Company/Institution ❑ Home ❑ Business

Address

City State/Province Country Zip

Phone Fax E-mail

Which organization do you belong to or are joining? ❑ ISCD ❑ NOF ❑ Both ❑ Neither

Primary Specialty (check one): ❑ Dietetics ❑ Emergency Medicine ❑ Endocrinology ❑ Family Practice ❑ Geriatrics ❑ Internal Medicine ❑ Nephrology ❑ Nuclear Medicine ❑ Obstetrics and Gynecology ❑ Oncology ❑ Orthopedics ❑ Pain Management ❑ Pediatrics ❑ Pharmacy ❑ Physical Therapy ❑ Physiatry ❑ Public Health ❑ Radiology ❑ Rehabilitation ❑ Research ❑ Rheumatology ❑ Other:_____

Practice Setting (check one): ❑ Academic Medical Center ❑ Community/Rural Health ❑ Hospital ❑ Military/Veteran's Administration ❑ Osteoporosis Center ❑ Outpatient Care Center ❑ Pharmacy ❑ Private Practice ❑ Rehabilitation Center ❑ Radiology/Diagnostic Center ❑ Research Facility ❑ Women's Center ❑ Other:_____

How did you hear about this Meeting? (check one) ❑ Calendar Listing ❑ Email ❑ Exhibitor Prospectus ❑ ISCD Web Site ❑ NOF Web Site ❑ Mailing ❑ Industry Rep ❑ Journal of Clinical Densitometry ❑ Osteoporosis International ❑ Other Professional Society_____ ❑ Other Publication_____

Type of Continuing Education you wish to receive: (check one) ❑ Physician ❑ Nurse ❑ Nurse Practitioner ❑ Physician Assistant ❑ Radiology Technologist (ASRT) ❑ Yes, I will require ASRT credit (special badge required)

Special Needs: ❑ I, or my guest, has special needs as defined by the ADA and will require assistance in order to participate fully. Indicate special needs _____

A. Pre-Conference Seminars – Attendees must register for symposium in order to be eligible to attend one of the pre-conference seminars. ***Additional fees apply*** – seminars are concurrent please select only one: seating is limited to 75 attendees in each seminar.

a. Osteoporosis Diagnosis and Risk Assessment	$75
b. Clinical Considerations: Therapeutics	$75
c. Comprehensive Approach to Treatment: Education, Nutrition, Exercise	$75

B. Registration Categories & Fees (circle appropriate fees)

	Early Bird Rate Until 01/15	Regular Rate Until 2/23	Onsite Rate After 2/23
Member ISCD Clinician; NOF PPN Member	$450	$550	$650
Member NOF Clinician (Non-PPN)	$525	$625	$725
Member Technologist/Allied Health Professional	$250	$350	$450
Non-Member Clinician	$675	$775	$875
Non-Member Technologist/Allied Health Professional	$375	$440	$540
International Clinicians	$450	$550	$650
International Technologists/Allied Health Professional	$250	$350	$450
Student/Resident/Retired/Federal Government Employee	$250	$275	$350
One Day Rate-Technologist/Allied Health Professional (select only one): ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday	$175	$230	$300
One Day Rate – Clinicians (select only one): ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday	$300	$350	$400
Guest (includes reception only) Guest Name_____	$75	$75	$75

International Attendees:

❑ Please check here if you will need an Invitation Letter in order to obtain a Visa to attend Clinical Osteoporosis 2010: An ISCD-NOF Symposium

ISCD Awards/Business Luncheon

❑ Check here if you are an ISCD Member or International Delegate and you would like to attend the ISCD Business Meeting and Presidential Awards Luncheon on Saturday, March 13, 12:00 p.m.-2:00 p.m.

Register for the Symposium

On-Line with credit card information at www.clinicalosteoporosis.org
Fax 202.223.2237
Mail Completed form with payment in full to:
Clinical Osteoporosis 2010
342 North Main Street
West Hartford, CT 06117

Federal ID # 161474752

Payment Options

Full payment must accompany your registration form. Enclose your check **(made payable to Clinical Osteoporosis 2010)** or complete the credit card information below and return via mail or fax. **Purchase orders will not be accepted.**

❑ **By Credit Card** Total Amount Due $_____

Please Bill My ❑ MasterCard ❑ Visa ❑ American Express

Exp. Date _____

(Please Print)
Card Holders Name (as shown on card) _____

Credit Card Holders Billing Address: ❑ Check here if same as above.

Address _____

City _____ State _____ Zip _____ Country _____

Card Holders Signature _____

❑ **By Check** (U.S. Dollars Only) Check #_____ Check Amount $_____