

Clinical Osteoporosis 2010: An ISCD-NOF Symposium

Registration Form



Registrant Information

(Please Print Clearly)

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 Psychiatry 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	\$175	\$230	\$300
(select only one):			
<input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday			
One Day Rate – Clinicians	\$300	\$350	\$400
(select only one):			
<input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday			
Guest (includes reception only)	\$75	\$75	\$75
Guest Name _____			

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.

Special Event: Buckhorn Museum – Dinner/Drinks/Networking

Thursday, March 11, 7:30 p.m.-10:30 p.m.
 \$75 per individual — Number of Tickets _____ Total \$ _____

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

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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 \$ _____