

*Institute of Women's Health & Integrative Medicine*

*April 23 - 25, 2010*

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**Registration Form**

**Name:**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Degree \_\_\_\_\_ Email \_\_\_\_\_

**Mailing Address:**

Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Form of Payment:** \$45.00 fee to be charged for any cancellations after April 5, 2010.

PLEASE CHECK ONE:

**Registration fee ON or BEFORE April 5, 2010**

- New Attendee - \$395.00
- Previous Attendee - \$375.00

**Registration fee AFTER April 5, 2010**

- New Attendee - \$460.00
- Previous Attendee - \$425.00

- Bill my credit card:
- Visa
- Mastercard
- Check is enclosed
- Amex
- Discover

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Signature \_\_\_\_\_

Registrations paid by credit card can be faxed to 503-222-0276.