American Thyroid Association
REGISTRATION FORM

Cardiovascular and Metabolic Issues in Patients with Thyroid Dysfunction: ***Implications for treating hypo- or hyperthyroidism***

Marriott Metro Center
Washington, DC
March 28, 2008

Deadline for receipt of advance registration is March 14, 2008

All requested information must be provided to process registration.
All Fees are in U.S. Dollars.

____
First name

____
Last name

____
Nickname for badge

Professional degree(s) (please list one): __________
a. MD   b. PhD   c. MD, PhD   d. RN   e. DO
f. Other: __________

____
Title

____
Organization

____
Address 1

____
Address 2

______________________ ______ ________________
City   State/Province   Zip code + 4

____________________ If outside the U.S., country/city code: ____
Country

(____)____________________ (____)_________________
Phone   Fax

____
E-mail address

Special Needs. (Dietary, accessibility, etc.) ______________________
____

1. I require a CME certificate for my attendance at this meeting. _____

2. I consider myself primarily (please list one): _____
a. Clinician   b. Educator   c. Scientist   d. Other: _________________

3. My work is best described as (please list one): _____
a. Adult endocrinology   b. Basic science
c. Pediatric endocrinology   d. Internal medicine
e. Family Medicine   f. Other: _________________

4. My place of work is (please list one): _____
a. Academic   b. Private practice   c. Administration
d. Hospital   e. Government/military   f. Corporate/industry
g. Managed care   h. Other _________________

5. Registration fees (please circle applicable fees):

	Discounted (received by March 14)	Full Fee (received after March 14)
(D) Physician/Scientist	$325	$375
(G) Government/Public Health Official	$325	$375
(P) Press	$0	$0
(F) Residents/Fellows/Allied Health Professional*	$125	$175

*With Verification of status**.** Please fax a letter from your program director to 703-998-8893 or by e-mail to thyroid@thyroid.org.

_____ Please check here if you wish to attend the Research Summit on Thursday March 27th from 12pm - 5pm for $125.00 (this fee does not include a registation for the Spring Symposium)

6. TOTAL FEES

Registration **$** ________
Fellows Travel Grant Donation **$** ________
Research Summit Registration **$** ________

Total....................................... **$** ________

7. Submission and payment -- Checks and money orders for registration payable to the **American Thyroid Association** in U.S. dollars drawn on a U.S. bank.
☐ MasterCard   ☐ VISA   ☐ American Express

____
Card number

____
Expiration date (month/year)

____
Print cardholder's name

____
Signature

REGISTER ON-LINE at the secure ATA web site www.thyroid.org.

FAX your completed form with credit card payment (no checks or money orders) to 678-341-3081. If you **FAX,** DO NOT MAIL, you risk duplicate charges.

MAIL your completed registration form with payment to: ATA Registration, c/o QMS, 6840 Meadowridge Court, Alpharetta, GA 30005. Phone 678-341-3056.

REFUND POLICY: Refund requests must be submitted in writing. Requests submitted by fax or e-mail before March 14, 2008 will receive a registration refund less a 50% processing fee. No refunds will be made if submitted after March 14, 2008. Refunds will be processed 30 days after the meeting.
Fax number: 703-998-8893. E-mail: thyroid@thyroid.org

In case of emergency, please contact:

Name____

Daytime Phone________________________

Evening Phone________________________

Please keep a copy of this form.