



## REFUND REQUEST FORM

**ATA REFUND POLICY:** Refund requests must be submitted using this Refund Request Form. Requests submitted by fax or e-mail before August 20, 2012, will receive a registration refund less a 50% processing fee. No refunds will be made if submitted after August 20, 2012. Refunds will be processed 30 days after the meeting.

All requested information must be provided to process a refund. All fees are in U.S. dollars.

REGISTRANT NAME: \_\_\_\_\_  
First
Middle
Last

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

ORIGINAL FORM OF PAYMENT:  MC/VISA  American Express  Check  Other \_\_\_\_\_

ORIGINAL PAYMENT:  Personal  Institution

NAME of the ORGANIZATION or INDIVIDUAL who originally paid the registration and is due the refund \_\_\_\_\_

ADDRESS 1 \_\_\_\_\_

ADDRESS 2 \_\_\_\_\_

CITY \_\_\_\_\_ STATE/PROVINCE \_\_\_\_\_ ZIP CODE + 4 \_\_\_\_\_ COUNTRY - IF OUTSIDE US, INCLUDE COUNTRY/CITY CODE \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

Reason for cancellation:

\_\_\_\_\_  
 \_\_\_\_\_

Submitted by:

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

Send this form

By email to [sbarger@thyroid.org](mailto:sbarger@thyroid.org) or

By fax to 703-998-8893 or

By mail to American Thyroid Association 6066 Leesburg Pike, Suite 550 Falls Church, VA 22041.

*Internal use:*

Date submitted: \_\_\_\_\_ Original payment: \_\_\_\_\_

Approved: \_\_\_\_\_ Amount due: \_\_\_\_\_

Form of Refund:  MC/VISA  American Express  Check # \_\_\_\_\_  Other \_\_\_\_\_