REFUND REQUEST FORM

ATA REFUND POLICY: Refund requests must be submitted using this Refund Request Form. Requests submitted by fax or e-mail before September 16, 2013, will receive a registration refund less a 50% processing fee. No refunds will be made if submitted after September 16, 2013. 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 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* _____