



REFUND REQUEST FORM

ATA REFUND POLICY: Refund requests must be submitted using this Refund Request Form. Requests submitted by fax or e-mail before March 22, 2013, will receive a registration refund less a 50% processing fee. No refunds will be made if submitted after March 22, 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 _____

