REGISTRATION FORM

15th Annual HIV Clinical Care Symposium
June 3-4, 2014
The Hilton Garden Inn-Troy, 235 Hoosick Street, Troy, NY 12180

Please type or print clearly & register one person per form. This form may be photocopied.

NAME & DEGREE (AS TO APPEAR ON CONFERENCE MATERIALS)

CME TRACKING NUMBER (MONTH OF BIRTH - DAY OF BIRTH - FIRST 4 CHARACTERS OF FIRST NAME)

SPECIALTY

ORGANIZATION

BUSINESS ADDRESS

CITY        STATE    ZIP

BUSINESS PHONE        BUSINESS FAX

HOME ADDRESS

CITY        STATE    ZIP

EMAIL ADDRESS (MUST INCLUDE AN E-MAIL ADDRESS IF YOU WOULD LIKE A LINK TO THE ON-LINE SYLLABUS SENT TO YOU)

Send confirmation to my □ Business Address □ Home Address □ E-mail Address

Please check method of payment:

□ My check for $________, payable to Albany Medical College is enclosed.

□ Charge my credit card for the amount of $__________.

☐ MasterCard    ☐ Visa    ☐ American Express    ☐ Discover

CARD NUMBER       EXPIRATION DATE

NAME AS IT APPEARS ON CREDIT CARD

SIGNATURE (REQUIRED FOR CREDIT CARD PAYMENT ONLY)

Method of Registration: Mail or Fax

Fax (518) 262–5679 registrations accepted with credit card payment only. Fax registrations without credit card information cannot be processed.

Return this form with payment to:
Albany Medical College
Office of Continuing Medical Education
Mail Code 1 Room J408, HIV Course Registration
47 New Scotland Avenue
Albany, New York 12208-3479

Office Use Only

Check #: ______________________
B/P Date Received: ______________
Amount: ______________________
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