TAYLOR MCADAM BELL
NEUROSCIENCE INSTITUTE

WASHINGTON HOSPITAL HEALTHCARE SYSTEM

Demographics

Last FIVE digits of Social Security Number: ___–___ ___ ___ ___ **required for CME credits*

This is how your name will appear on your name badge. **required*

First Name: _____

Last Name: _____ Suffix (Jr., Sr., etc.): _____

Company/Institutional Affiliation: _____

Specialty: _____

Degree: ☐ MD ☐ DO ☐ PhD ☐ MS ☐ RN **required*

☐ Other, please indicate: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Telephone ( ) _____ Fax ( ) _____

Email Address: _____

How did you hear about this course?

☐ Direct Mail ☐ Email ☐ Place of Employment ☐ Word of Mouth

Special Dietary Requirements: _____

Registration Fees

Perfexion Upgrade Course Fee	Physics Course Fee
$3,000	$3,500

Total Due: _____

Payment must accompany registration.

Requested 2010 Course Date*

Upgrade Course: ☐ Feb. 1-3 ☐ June 14-16 ☐ Oct. 4-6

Physics Course: ☐ Apr. 12-14

**minimum attendance required*

Method of Payment

The following methods of payment are acceptable for the registration fee:

1. Checks: **Make payable to Washington Hospital Healthcare System**
2. Credit Card Payments *(We encourage all credit card users to register by phone)*
   ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
   Credit Card No.: _____
   CVD No.: _____ *(3-digit number on the back of your credit card)*
   Expiration Date _____ *(month/year)*
   Signature _____

Fax completed form to (510) 791-3496