REGISTRATION

COURSE FEES

SPECIAL REQUIREMENTS

Please print or type.	Physicians\$100	If you have special needs—dietary, access, parking—please describe:
(You may photocopy this form for additional registrants.)	Mid level-physician assistant & nurse practition \$75	parking—please describe.
Name:	RN, LPN, RTR\$50	
(As it should appear on your name tag and certificate)	Medical Students / Residents / FellowsNC	
Degree (MD, PhD, RN, etc.)	Will you be attending reception ? ☐ Yes ☐ No	
Primary State of Licensure:	'	
Professional License Number:	Additional guests #x \$25 =	
Date of Birth :	TOTAL ENCLOSED \$	Fax registration form to: (304) 599-0796 Information: (304) 598-4651
(Optional)	*Course fees include conference materials, lunch, breaks, and continuing education credits.	Email: cardiovascular excellence@gmail.com
Firm:		Mail this registration form to:
Mailing Address:	☐ Visa ☐ MasterCard ☐ Discover ☐ Am. Exp. Card Number:	Cardiovascular Excellence 364 Patterson Dr. #302
City:		Morgantown, WV 26505
State: Zip:	CVV code:	We reserve the right to cancel individual sessions or
County:	(The CVV code appears as three or four digit numbers printed on the reverse side of the card on the signature panel following the account number.)	the entire conference. In the event of a cancellation, a full tuition refund will be made.
Office Telephone: ()	Expiration Date:	
Home Telephone: ()	Cardholder Name:	
Fax Number: ()	Cardholder Full Billing Address:	
Email:	Authorization Signature:	
Specialty:	Checks made payable to: Cardiovascular Excellence	
Subspecialty:		www.cardiovascularexcellence.com