

**Registration Form**

**Scientific Conference in Stereotactic Body Radiation Therapy:  
Innovations and Directions for Clinical Application**



**June 13-14, 2008**

**University of Rochester Medical Center**

*Please Print Clearly*

Name/Title \_\_\_\_\_

Birth Month and Day (for record keeping only) \_\_\_\_ / \_\_\_\_

(ex: June 16<sup>th</sup> = 06/16)

M M D D

Address \_\_\_\_\_

Suite # \_\_\_\_\_ Box # \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Institution/Affiliation \_\_\_\_\_

Practice Specialty \_\_\_\_\_

Office Phone \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_

**FEES:**

Conference Registration:

\_\_\_\_\_ Faculty, Clinicians, Physicists, Dosimetrists \$250 per person

\_\_\_\_\_ Students, Post-Docs \$100 per person

Friday Dinner Gala:

\_\_\_\_\_ All Conference Attendees \$65 per person

\_\_\_\_\_ # of Additional Guest Tickets \$65 per person

Guest Name \_\_\_\_\_

Special Dietary Needs: \_\_\_\_\_

**METHOD OF PAYMENT:**

\_\_\_\_\_ Check Payable to: Continuing Professional Education

\_\_\_\_\_ CME Voucher + \$ \_\_\_\_\_ (if applicable)

\_\_\_\_\_ Nursing Voucher + \_\_\_\_\_ (if applicable)

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**Please return this form with payment to:**

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If paying by credit card, you may fax your registration to our office. Copies of this form are acceptable.  
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