79th Annual Educational Conference of the Catholic Medical Association

RESTORING THE Integrity OF MEDICINE

CONFERENCE REGISTRATION

This registration form, along with the appropriate registration fee selected from below, must be returned no later than September 30, 2010, to ensure your place at the conference.

Name: _____

Email: _____

Specialty: _____ Registrant's Degree: _____

CME Credit Requested: Yes ☐ No ☐ Type of Credit: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____

Spouse / Guest Name: _____

Please fill out a separate form for each non-family member.

FULL CONFERENCE PACKAGE

Includes Registration, Breakfasts, Lunches, and Saturday Evening Banquet

CMA MEMBERS

Physicians & Dentists	$655	$_____
After August 31	$715	$_____
Other – Spouse, Priest, Religious, Student, Allied Health Professional, Resident; General Public *(please circle one above)*	$435	$_____
After August 31	$490	$_____

NON-CMA MEMBERS

Physicians & Dentists	$765	$_____
After August 31	$825	$_____
Other – Spouse, Priest, Religious, Student, Allied Health Professional, Resident; General Public *(please circle one above)*	$490	$_____
After August 31	$545	$_____

SINGLE-DAY REGISTRATION

Includes everything for a single day (except Special Event and Banquet) Circle day(s): Thur. Fri. Sat.

Physicians & Dentists	$325	$_____
After August 31	$385	$_____
All Others	$250	$_____
After August 31	$305	$_____

FRIDAY'S SPECIAL EVENT

Not Included in the Full Conference Package
Event attendance is limited to 150 people

An Evening with G. K. Chesterton & Exquisite Northwest Desserts and Wines

Adults	$90	$_____
Children 12 & under	$45	$_____

SATURDAY EVENING BANQUET

Included in Full Conference Package

Extra Tickets	Adults $125	$_____
	Children 10 & under $20	$_____

☐ I would like to order a complete set of Audio CDs at a ***special pre-conference price of $175*** $_____

DONATION OPPORTUNITIES

☐ I would like to be a conference sponsor with a tax-deductible donation of $_____

☐ I would like to donate to the Medical Student Development and Scholarship Fund with a tax-deductible donation of $_____

☐ I would like to support the CMA Medical Missions with a tax-deductible gift of $_____

Registration may be submitted via regular mail or via the CMA Web site: www.cathmed.org

TOTAL PAID $_____

Please make checks payable to Catholic Medical Association and mail (or fax: 866-666-2319) the completed form to:
Catholic Medical Association, 29 Bala Ave., Suite 205, Bala Cynwyd, PA 19004-3206

☐ Visa Cardholder Name: _____

☐ MC Card Number: _____

☐ AmExp Expiration Date: _____ Amount Authorized: $ _____

Cardholder Signature: _____

REFUND POLICY: A refund will be given if notification is received in writing on or before September 30, 2010, minus a $75 administration charge. Sorry, no refunds after September 30, 2010. No exceptions.