



AVIDsymposium Registration

Friday, November 19 - Saturday, November 20, 2010

First Name: _____ Last Name (Surname, Family Name): _____ Degree: _____

Physician Non-Physician Cleveland Clinic Employee? Yes No Specialty: _____

Affiliation: _____

Address Type: Home Other Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____

E-mail: _____ *(A valid registrant's email address is required for confirmation and CME Certificate)*

Alternate E-mail (contact person): _____ Phone: _____ Fax: _____

Full Registration (Friday - Saturday)

	Tuition*
<input type="checkbox"/> Practicing Physicians	\$695
<input type="checkbox"/> Practicing Physicians Combination Rate - AVIDsymposium, VEITHsymposium and AIMsymposium	\$1895
<input type="checkbox"/> PhDs <input type="checkbox"/> Physician Assistants	\$695
<input type="checkbox"/> Residents <input type="checkbox"/> Nurses <input type="checkbox"/> Technologists	\$500
<input type="checkbox"/> Medical & Ultrasound Students <i>(Letter of verification from Dean must be faxed to 845-496-2242.)</i>	\$175
<input type="checkbox"/> Allied Health Care Professionals	\$650

(Companies exhibiting at the meeting must use the Industry Registration Form to register their representatives. Please visit the [Exhibit](#) page on www.AVIDsymposium.org to download a copy of this form.)

*** Please add \$100 to ALL tuition categories if registering at event location. Please visit www.AVIDsymposium.org to review our Cancellation Policy.**

Payment Method (If paying by wire transfer, please add \$30.00 US to total amount due.)

Check Please make checks payable to the Cleveland Clinic Educational Foundation and mail to:
 The Cleveland Clinic Educational Foundation
 Attn: 020668
 P.O. Box 931653
 Cleveland, OH 44193-1082

Name on Card _____ Check Amex MC VISA

Credit Card Number _____ Verification Code (3- or 4- digit security code located on your card) _____

Expiration Date _____ Signature _____