REGISTRATION FORM

RTOG® RADIATION THERAPY ONCOLOGY GROUP

Semiannual Meeting

Westin Peachtree Plaza Hotel, Atlanta, GA
January 19-22, 2012

Please return this form by January 6, 2012 to:
American College of Radiology/RTOG Meeting
P.O. Box 2348 • Merrifield, VA 22116-2348
or fax to: 703-648-1863 (credit card payment or no-fee registrations)
QUESTIONS? CALL: 800-373-2204

Last Name | First Name | MI | Degree

Institution/Company Name | Department

Street Address

City | State or Province | ZIP Code | Country (if not US)

Please indicate if above address is: ❑ Business ❑ Home

Business Phone

Home Phone

Business Fax

Home Fax

Business E-mail

Home E-mail

Preferred Name on Your Badge

Companion/Guest - Name(s)

❑ First-Time Attendee

Registration Fees: *(check if appropriate)*

❑ Corporate Attendee (Not Exhibiting) **$ 300**
❑ Corporate Attendee (Exhibiting or Sponsor) ***No Fee***

TOTAL FEE, IF ANY: $ _____

I Will Attend:

❑ RTOG Symposium
❑ Plenary Session/Keynote Address
❑ RA Audit Workshop
❑ Quality of Life Training Session
❑ Brain Tumor Committee
❑ Breast Cancer Working Group
❑ GI Cancer Committee
❑ GU Cancer Committee
❑ GYN Cancer Working Group
❑ Head & Neck Cancer Committee
❑ Lung Cancer Committee
❑ Saracoma Working Group
❑ Publications Scientific Session
❑ Advanced Technology Integration Committee
❑ Medical Oncology Committee
❑ HSRO & Sym Mgt Committees
❑ Translational Research Program
❑ All-Attendee Reception
❑ Friday Box Lunch ❑ Saturday Box Lunch

My Discipline: *(Please check one)*

❑ Administrator
❑ Corporate Attendee
❑ Data Manager
❑ Diagnostic Radiologist
❑ Medical Dosimetrist
❑ Medical Oncologist
❑ Pathologist
❑ Patient Advocate
❑ Physicist
❑ Radiation Oncologist
❑ Radiation Therapist
❑ Radiobiologist
❑ Registered Nurse
❑ Research Associate
❑ RTOG Staff
❑ Surgeon
❑ Tabletop Exhibitor

Social Security Number (last four digits) – International Members - Birthdate (DDMM) (to identify you in our database)

Method of Payment:

Payment must accompany the registration form. Please check one method of payment:

❑ Check: Please make payable to:
American College of Radiology

Credit Card: ❑ VISA ❑ MasterCard ❑ AMEX

Card No. | Expiration Date

Signature of Cardholder

Name of Cardholder *(please print)*

If you do not receive a meeting confirmation within two weeks of your registration form submission, please call 800-373-2204.

Full refunds, less a $75 administrative fee, will be granted only in response to a written notification of cancellation received 48 hours prior to meeting. No refund of any amount will be granted for "no-shows" or cancellations received less than 48 hours prior to the meeting.