MEETING REGISTRATION

RTOG Semi-Annual Meeting

Sheraton Wild Horse Pass Resort and Spa • Phoenix, AZ • January 20-23, 2005

STOP

You must enter your RTOG Institution # _____

❑ Not affiliated with a RTOG Institution

In the event of cancellation, the American College of Radiology must receive notification in writing by December 21, 2004 in order to receive a refund.

Name _____

Institution/Company Name _____

Department _____

Street Address _____

City _____ State _____ Zip Code _____

Country (if not U.S.) _____ ❑ Companion/Guests – Name(s) _____

Please indicate if above address is: ❑ Home ❑ Office **Note: This is where your confirmation and CME letter will be sent.**

Office Phone ( ) _____ Home Phone ( ) _____

FAX ( ) _____ E-Mail _____

Social Security Number (last four digits) – ☐☐☐☐

❑ **This is the first RTOG Meeting I have attended.**

Registration Fees *(check if appropriate)*

❑ Corporate Attendee (Not Exhibiting)	**$ 300.00**
❑ Corporate Attendee (Exhibiting or sponsor)	***No Fee***
❑ With CME Credit	**$ 300.00**
❑ Institutional, Committee Member	***No Fee***
❑ Staff	***No Fee***
❑ With CME Credit	
❑ Non-member	***No Fee***

Special Events I Will Attend:

❑ Research Associates' Orientation* **$ 50.00**

* *Research Associates — You must check off Research Associates Orientation in order to reserve a space. This session fills up quickly. Submit by 12/2/2004*

Do not make any hotel or airline reservations until you receive confirmation indicating you are registered (not wait listed) for the orientation session.

❑ RTOG & ASTRO Biochemical Failure Definition Symposium and Consensus Panel ***No Fee***

TOTAL FEES, IF ANY: $ _____

If you do not receive a meeting confirmation within 2 weeks of your registration form submission please call (800) 373-2204.

My Discipline *(Please check one)*

❑ Radiation Oncologist ❑ Pathologist
❑ Radiation Therapist ❑ Registered Nurse
❑ Medical Oncologist ❑ Physicist
❑ Research Associate ❑ Corporate Attendee
❑ Surgeon ❑ Tabletop Exhibitor
❑ Other: _____

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 ❑ AmExpress

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Card No.

☐☐-☐☐ Expiration Date

_____
Signature of Cardholder

_____
Name of Cardholder *(please print)*

Please return this form by December 20, 2004 to:
American College of Radiology/RTOG Meeting
P.O. Box 2348 • Merrifield, Virginia 22116-2348
or FAX to: (703) 648-1863 (credit card payment or no-fee registrations)
QUESTIONS? CALL: (800) 373-2204