Women's Imaging 2008
February 3-6, 2008 / The Westin La Cantera Resort / San Antonio, TX
Conference Registration Form

THE REGISTRATION FEE MUST ACCOMPANY THE REGISTRATION FORM

Please PRINT Legibly and Complete All Sections

Name_____
First Name Last (Family) Name Title/Position

Degree (Circle One) *MD/DO PhD/ScD NP/PA RT RN Other* _____

Specialty (Circle One) *GYN SURG RAD IT ADMIN Other* _____

Institution/Affiliation _____

Address (☐ Home / ☐ Business)_____

City_____State_____Zip+4_____

Office Telephone_____FAX_____

E-mail Address_____

REGISTRATION FEES:	**By 12/15/07**	**After 12/15/07**
❑ Physicians/Other Healthcare Professionals	$595	$695
❑ Residents, Fellows, Nurses, Technologists	$475	$595
❑ Spouse/Companion *(includes reception, breakfasts, lunches & breaks)*	$145	$145
Spouse/Companion Name (for badge) _____		
Group Discount*		
❑ Physicians/Other Healthcare Professionals	$535	$625
❑ Residents, Fellows, Nurses, Technologists	$425	$535
** 3 or more from same institution/office must register at the same time*		
❑ 2 Day (Sunday – Monday only) Rate	$425	$525
❑ 1 Day Rate (circle day: Sun. Mon. Tues. Wed.)	$275	$275
❑ On-Site Registration	N/A	$745
WORKSHOP FEES Must pre-register (Space Limited):		
❑ US Breast Biopsy Workshop	N/C	N/C
❑ Multi-modality Breast Imaging Workshop	N/C	N/C
❑ MR-guided Breast Biopsy Simulator	N/C	N/C

Total Payment: _____

SIGN UP FOR THE FOLLOWING ACTIVITIES:

WELCOME RECEPTION
SUNDAY, FEBRUARY 3, 2008

❑ I Will Attend ❑ I Will NOT Attend
❑ Spouse/Companion Will Attend *(separate fee required)*

TRANSPORTATION TO THE RIVERWALK
MONDAY, FEBRUARY 4, 2008

_____ # of seats needed

PLEASE COMPLETE THE FOLLOWING:

How did you hear about this meeting?

❑ Brochure ❑ Postcard ❑ Website
❑ Colleague ❑ Magazine ❑ Other

Please check all that apply at your institution/office:

❑ PACS installed
❑ Changing PACS
❑ Looking for a PACS vendor

Vegetarian Lunch Required? ❑ Yes ❑ No

METHOD OF PAYMENT:

❑ Check **(payable to: Univ. of Rochester, Dept. of Imaging Sciences WI2008)**
❑ Credit Cards accepted: ❑ Visa ❑MasterCard ❑Discover

Card Number: _____Exp. Date _____

Name on Card: _____

Signature _____

Please Return Form With Payment To:

Sue Nielsen, Events Coordinator
Department of Imaging Sciences
University of Rochester Medical Center
601 Elmwood Avenue, Box 648
Rochester, NY 14642-8648
Fax: 585-276-2406
E-mail: Sue_Nielsen@urmc.rochester.edu

If paying by credit card, you may fax your registration to the Events Coordinator. Copies of this form are acceptable. Please do not reduce this form. For non-US registrants, payment MUST be in US Dollars only. **Cancellation Policy:** All cancellations must be made in writing and sent to the Events Coordinator prior to 1/1/08. An administrative fee of $75.00 will be deducted from all refunds. No refunds will be issued after 1/1/08.