

**REGISTRATION FORM**  
**2006 Heart Valve Summit**

**H0626-W**  
**June 15-17, 2006**

Membership Number (If applicable) \_\_\_\_\_

Last Name **(Please print clearly)** \_\_\_\_\_

MD       DO       PhD       RN       Other \_\_\_\_\_  
 Please specify

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

What is your primary medical specialty: (Check one)

Adult Cardiology       Pediatric Cardiology       CV Surgery  
 Internal Medicine       Pharmacology       Radiology  
 Family/General       Other \_\_\_\_\_

**Registration Deadline: June 1, 2006**

<b>Please register me as:</b>	<b>Early Bird until 4/15/06</b>	<b>Advance 4/15/06 - 6/1/06</b>	<b>Onsite Only</b>
Member Physician	<input type="checkbox"/> \$600	<input type="checkbox"/> \$750	<input type="checkbox"/> \$900
International Associate	<input type="checkbox"/> \$650	<input type="checkbox"/> \$800	<input type="checkbox"/> \$950
Nonmember Physician	<input type="checkbox"/> \$700	<input type="checkbox"/> \$850	<input type="checkbox"/> \$1,000
Reduced <input type="checkbox"/> FIT <input type="checkbox"/> Emeritus <input type="checkbox"/> Resident	<input type="checkbox"/> \$350	<input type="checkbox"/> \$500	<input type="checkbox"/> \$650
CCA Member <input type="checkbox"/> PA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> CNS	<input type="checkbox"/> \$350	<input type="checkbox"/> \$500	<input type="checkbox"/> \$650
Tech/Sonographer	<input type="checkbox"/> \$350	<input type="checkbox"/> \$500	<input type="checkbox"/> \$650
CCT Non member <input type="checkbox"/> PA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> CNS	<input type="checkbox"/> \$400	<input type="checkbox"/> \$550	<input type="checkbox"/> \$700

Special Dietary Requirements: (Advance notification required)

Fruit       Kosher       Vegetarian       No seafood

Payment must accompany application.

Check payable to American College of Cardiology Foundation in US dollars drawn on a US bank

MasterCard       VISA       American Express       Discover

Cardholder's Name (Please print clearly.) \_\_\_\_\_ Signature \_\_\_\_\_

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Disability Accommodations** \_\_\_\_\_  
 Please advise us of your needs.

Please use just **ONE** of these ways to register: **(DO NOT MAIL if previously faxed, telephoned, or registered online.)**

**MAIL:** Application and payment to American College of Cardiology Foundation, Attn: Resource Center, P.O. Box 79231, Baltimore, MD 21279-0231.

**TELEPHONE:** 800-253-4636, ext. 694. Outside the US and Canada, 301-897-5400, ext. 694

**FAX:** 301-897-9745 – Attn: Resource Center

**ONLINE:** [www.acc.org](http://www.acc.org)