

REGISTRATION FORM
ACCF Cardiovascular Board Review for Certification and Recertification
September 6-11, 2006



Membership Number (If applicable) _____

Last Name (Please print clearly) _____

MD DO PhD

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: August 23, 2006

Please register me as:	Early Bird until 7/1/06	Advance 7/2/06 - 8/23/06	Onsite after 8/23/06
Member Physician	<input type="checkbox"/> \$950	<input type="checkbox"/> \$1,100	<input type="checkbox"/> \$1,250
International Associate	<input type="checkbox"/> \$1000	<input type="checkbox"/> \$1,150	<input type="checkbox"/> \$1,300
Nonmember Physician	<input type="checkbox"/> \$1,050	<input type="checkbox"/> \$1,200	<input type="checkbox"/> \$1,350
CCA Member <input type="checkbox"/> PA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> CNS	<input type="checkbox"/> \$550	<input type="checkbox"/> \$700	<input type="checkbox"/> \$850
Reduced <input type="checkbox"/> FIT <input type="checkbox"/> Emeritus <input type="checkbox"/> Resident	<input type="checkbox"/> \$550	<input type="checkbox"/> \$700	<input type="checkbox"/> \$850
Tech/Sonographer	<input type="checkbox"/> \$550	<input type="checkbox"/> \$700	<input type="checkbox"/> \$850
CCT Non member <input type="checkbox"/> PA <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> CNS	<input type="checkbox"/> \$600	<input type="checkbox"/> \$750	<input type="checkbox"/> \$900

Special Dietary Requirements: (Advance notification required)

Fruit Kosher Vegetarian

Payment must accompany application.

Check - made 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 _____

Special Needs _____
 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

2006-1602