

Registration Form

Interactive ACCF Study Session for Maintenance of Certification

Membership Number (If applicable) _____

Last Name **(Please print clearly)** _____

MD DO PhD RN Other (specify) _____

First Name _____

Middle Initial _____

Address _____

City _____

State _____

Zip _____

Office Telephone _____

Fax _____

Email _____

What is your primary medical specialty? (Check ONE)

Adult Cardiology Pediatric Cardiology CV Surgery
 Internal Medicine Pharmacology Radiology
 Family/General Other (specify) _____

Registration Deadline:

March 4, 2006

Advance
on or Before Mar. 4

Late/On-Site
After Mar. 4

Please register me as:

ACC Member Physician

\$375

\$475

Nonmember Physician

\$450

\$550

Special Dietary Requirements: (Advance notification required)

Fruit Kosher Vegetarian

Payment must accompany application

Check payable to American College of Cardiology Foundation in U.S. dollars drawn on a U.S. bank.

MasterCard VISA American Express Discover

Cardholder's Name **(please print clearly)** _____


Card Number _____

Expiration Date _____


Disability Accommodations (please check)

Please advise us of your needs.

Please use ONE of these methods to register: (Do not mail if previously faxed or telephoned)

 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 applications: 301-897-9745 – Attn: Resource Center

2006-1686