



REGISTRATION FORM

Cardiovascular Summit - February 22-24, 2018; Cosmopolitan Hotel, Las Vegas, NV

Please use **ONE of these methods** to register; (do not mail if previously faxed, telephoned or registered online)

1. **Mail** completed form and payment to: American College of Cardiology; Attn: Resource Center P.O. Box 37561, Baltimore, MD 21297-3561
2. **Fax** the registration form to: 202-375-7000; **Call** 800-253-4636, ext. 5603, or (Outside the U.S and Canada, 202-375-6000, ext. 5603)
3. **Visit** ACC.org/CVSummit18 to register online

Membership Number (If applicable)

Last Name (Please print clearly) _____ **First Name** _____ **Middle Initial** _____
☐ MD ☐ DO ☐ PhD ☐ RN ☐ NP ☐ PA ☐ CNS ☐ Other _____

Street Address

City _____ **State** _____ **Zip** _____

Office Phone _____ **Office Fax** _____ **Email** (Please print clearly) _____

Practice Administrator's Name _____ **Phone** _____

What is your primary medical area of interest: (Check one)

- ☐ Adult Cardiology ☐ CV Surgery ☐ Family/General ☐ Internal Medicine ☐ IV Cardiology ☐ Ped. Cardiology ☐ Radiology ☐ Other _____

REGISTRATION TUITION

Please register me as:	Designation	Pre-conference Workshop - Basics	Pre-conference Workshop - Leadership	Early Until 11/29/17	Regular 11/30/17 Until 2/7/18	Late 2/8/18 and Onsite
ACC/AAPL/HRS/SCAI/Advisory Board/MedAxiom/Navigant Member Physician (includes International Associate)	MD, DO, PhD	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$975	<input type="checkbox"/> \$1175	<input type="checkbox"/> \$1275
Non-member Physician (includes Industry Professional)	MD, DO, PhD	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$1350	<input type="checkbox"/> \$1550	<input type="checkbox"/> \$1650
ACC/AAPL/HFSA/HRS/SCAI Member Executive	CEO, COO, CFO, Director	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$875	<input type="checkbox"/> \$1075	<input type="checkbox"/> \$1175
Non-member Executive	CEO, COO, CFO, Director	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$1200	<input type="checkbox"/> \$1400	<input type="checkbox"/> \$1500
ACC/AAPL/HRS/SCAI/Advisory Board/MedAxiom/Navigant Member CV Administrator	PA, RN, NP, CNS, PharmD, FIT, Student, Emeritus, Resident	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$550	<input type="checkbox"/> \$750	<input type="checkbox"/> \$850
BUNDLE for Non-member CV Administrator to Become an ACC MEMBER (includes ACC CV Administrator membership fee through 2018)*	PA, RN, NP, CNS, PharmD	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$750	<input type="checkbox"/> \$950	<input type="checkbox"/> \$1050
Non-member CV Administrator	PA, RN, NP, CNS, PharmD	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$850	<input type="checkbox"/> \$1050	<input type="checkbox"/> \$1150
ACC/AAPL/HRS/SCAI/Advisory Board/MedAxiom/Navigant (includes CVT Member, FIT, Resident, Student and Emeritus)	PA, RN, NP, CNS, PharmD, FIT, Emeritus, Resident, Student	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$550	<input type="checkbox"/> \$750	<input type="checkbox"/> \$850
Non-member Reduced	PA, RN, NP, CNS, PharmD	<input type="checkbox"/> \$150	<input type="checkbox"/> \$150	<input type="checkbox"/> \$750	<input type="checkbox"/> \$950	<input type="checkbox"/> \$1050

*Proof of licensure required for PA, Tech, RN, CNS and NP (non-CVT members); letter from training director needed for FIT. International registrants are urged to FAX application to the ACC. *Contact the Resource Center at 800-253-4636, ext. 5603 or fax the registration form to 202-375-7000 to receive this discount.*

Register your group of 5 or more and save! Call the Resource Center at 800-253-4636, ext. 5603 with the codes below to register your group:
CVGRP10 — 10% discount for groups of 5-9 registrants **CVGRP15 — 15% discount for your group of 10 or more**

Payment must accompany application. ☐ Check payable to: American College of Cardiology, in US dollars drawn on a US bank

- ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Cardholder's Name (Please print clearly) _____ Signature _____

Card Number _____ Expiration Date _____ Security Code _____

☐ **Special Needs** (Please advise us of your needs) _____ **Special Dietary Requirements: (Advance notification required)** ☐ Vegetarian ☐ Other _____ (Please Specify) ACC staff will contact you to verify if this Special Meal Request can be accommodated