

Integrating Interventional Pain Management and Supportive Care in Patients Diagnosed with Cancer "Cancer Pain Conference"

Scottsdale Hilton Resort and Villas, Scottsdale, AZ

Friday, April 29 - Sunday, May 1, 2011

Please complete all requested information on this form, sign and return to: **scan/mailed, faxed or mailed forms accepted**

Michelle Byers MHByers@gmail.com, cell: 415-518-5391 fax: 951-302-4841

AMA Category 1 CME credit hrs. available for medical/scientific sessions through the WVSIPP. Units credited commensurate with the number of credit hrs. attended.

Session Registration: *use a separate form for each person if a different credit card will be charged*

- Please do let us know if you will be attending the Friday night welcome reception and if you will be bringing a guest

<u>Qty.</u>	<u>Session Description</u>	<u>Fee</u>	<u>Qty.</u>	<u>Session Description</u>	<u>Fee</u>
_____	Physician	\$750.00	_____	Industry Attendee	\$750.00
_____	Nurses	\$450.00	_____	Faculty	N/C
_____	Physician – Returning student	\$700.00	_____	Midlevel Practitioner/Fellows	\$600.00
_____	Live Demonstration Course	N/C	_____	Hospice Employee	\$450.00
_____	Evening Event Guest Registration	\$250.00	_____	Practice Manager	\$500.00
_____	Total Registration Fee	\$ _____			

***Evening event registration is included with all registration fees –evening events are non-CME events, are not industry supported and are open to registered guests**

All registrations received prior to 9/28/2010 are eligible for a \$100 discount on medical sessions – PainCAP members are eligible for a \$100 discount on all medical sessions. All registrations received prior to 12/31/10 are eligible for a 10% discount. Registrations received after 4/1/11 will be assessed a \$50.00 late fee

Name Badge and Contact Information *(additional name badge form attached)*

Last Name: _____ First Name: _____ MI: _____

Check One: **Dr.** ___ **Mr.** ___ **Mrs.** ___ **Ms.** ___

Badge Name: _____ *(Appears on Name Badge)*
(Example: John Smith, MD)

Institution/Organization _____ **Vendor/Exhibitor:** ___ **Yes** ___ **No**

Work Phone: _____ Fax: _____ Mobile Phone: _____

E-mail: _____ Web Page: _____

Mailing Address: _____

City, State, ZIP: _____

Accommodations – The Scottsdale Hilton Resort and Villas, Scottsdale, AZ

Guestroom Rate @ \$129.00 Per Room/Per Night

Friday & Saturday (29th & 30th) _____ Thursday - Saturday (28th - 1st) _____ Additional nights _____

Guests are welcome to register for hotel accommodations directly online at:
http://www.hilton.com/en/hi/groups/personalized/SCTSHHF-CCO-20110425/index.ihtml?WT.mc_id=POG utilize group code: Center for Pain and Supportive Care

Method of Payment

___ Check *(Make payable to The WVSIPP)*

___ VISA ___ MC ___ AMEX

Credit Card # _____ Exp. _____

Security # _____ (3-4 digits on reverse side of card)

Cardholder's Name: (as it appears on card) _____

Billing Address: (if different from mailing address) _____

Cardholder's Signature: _____ Date: _____