



Aesthetic Medicine Symposium

Please complete and Fax (toll-free) to: 1-866-284-9318

SYMPOSIUM DATE:		HOW DID YOU HEAR ABOUT THE SYMPOSIUM:	
NAME (As you would like it shown on the Certificate):			
LAST:	FIRST:	MIDDLE INITIAL:	MEDICAL DESIGNATION:
BILLING ADDRESS: <input type="checkbox"/> Home <input type="checkbox"/> Practice (must match credit card billing address)			
STREET:	CITY:	STATE:	ZIP CODE:
CELL PHONE:		EMAIL ADDRESS:	
PRACTICE NAME:			
PRACTICE ADDRESS (if not entered above):			
STREET:	CITY:	STATE:	ZIP CODE:
PRACTICE TELEPHONE:		PRACTICE FAX: n/a	
SPECIALITY(IES)/SUBSPECIALITY:		MEDICAL SOCIETY/ORGANIZATIONS MEMBERSHIPS:	
MEDICAL LICENSE #:	STATE/JURISTITION:	DATE ISSUED:	DATE EXPIRED:
OTHER LICENSES (State date issued):			
MEDICAL SCHOOL:	LOCATION OF SCHOOL (State or Country if not U.S.):		YEAR GRADUATED:
SYMPOSIUM OPTIONS (Physician):	<input type="checkbox"/> \$2,195 IAPAM Accredited Member Early Registration Discount for 2 Day Symposium (a member saving of \$1,100) <input type="checkbox"/> \$295 - I want to join the IAPAM as an Accredited Member today to get the (above) member Symposium price <input type="checkbox"/> \$595 Attend the Medical Weight Management Program <u>Choose One (Optional Monday):</u> <input type="checkbox"/> \$ 595 Business Track "Aesthetic Practice Startup Workshop" (\$995 non-members)		
	Additional Attendees (if applicable): <input type="checkbox"/> \$ 1,595 Colleague (MD/DO, NP, RN) pricing for 2 Day Symposium (injector) <input type="checkbox"/> \$ 1,095 Assistant pricing for 2 Day Symposium (non-injector) <input type="checkbox"/> \$ 395 Attend the Medical Weight Management Program (if also attending the AMS) <input type="checkbox"/> \$ 595 Optional 3 rd Day Business Track "Aesthetic Practice Startup Workshop" (Monday 8-2:30pm)		
ADDITIONAL ATTENDEE(s): NAME, DESIGNATION & E-MAIL:			
PAYMENT TYPE: Credit Card: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX			
CARD NUMBER:	EXPIRY DATE:	CARD VERIFICATION NUMBER:	
	/ (mm/yr)	(3 digit number on back of card after the card number)	
NAME AS IT APPEARS ON CREDIT CARD:			

* PLEASE NOTE: YOU WILL RECEIVE A CHARGE ON YOUR CREDIT CARD STATEMENT FROM: IAPAM

CANCELLATION POLICY:

Once your payment has been received and processed, you will receive an e-mail confirmation. If for some reason you cannot attend the symposium you must give at least 7 days notice to receive a full credit for a future symposium, no refunds will be given. If for some unforeseen the symposium is cancelled, you will receive a full refund limited to the registration fees already paid. The IAPAM is not responsible for non-refundable airline tickets, related travel costs, hotel accommodations purchased, or any other out of pocket expense you may incur. Symposium locations, agendas, and speakers are subject to change.

I hereby affirm that the information provided on this application is true, current, and correct. This symposium attendance is limited to active licensed physicians (i.e. MD, DO) in good standing. We reserve the right to refuse registration from any attendee. You hereby release all persons and entities, including the IAPAM, their employees and agents, from any liability they might incur for their acts, omissions, and/or communications arising from this application, to the extent those acts, omissions and/or communications are protected by state, federal and/or international law. I understand and agree to the terms of the IAPAM's Privacy Policy that can be found on the IAPAM's website. I hereby authorize the IAPAM and PCA to charge my credit card that I have listed above, for the amounts indicated. The IAPAM is not responsible for additional credit card charges your bank may charge.

SIGNATURE: _____ **DATE:** _____