

2010 ASCO Annual Meeting Individual Patient Advocate Registration Form

Patient Advocacy Organizations may register up to two representatives to attend ASCO's Annual Meeting at a reduced rate of \$255 per person on or before April 28, 2010, and \$330 per person beginning April 29, 2010. Additional representatives are welcome to register at the regular registration rate of \$755 per person on or before April 28, 2010, and \$905 per person beginning April 29, 2010.

Reduced registration is reserved exclusively for patient advocates and is not intended for medical professionals. Individuals interested in registering under this category must meet ASCO criteria that has been established for this category and may also be asked to provide a curriculum vitae. Individuals registered under this category are not eligible to receive continuing education credit for their attendance at the Meeting. Ticketed Sessions are also not available at this rate. Individuals interested in receiving continuing education credit should register at the appropriate attendee rate.

INDIVIDUAL PATIENT ADVOCATE REGISTRATION

Please print clearly or affix a label. Illegible forms will be returned. Please use the address at which you would like to receive your Meeting materials.

(For office use only: Registration Type: ATT, Member Type: 48 (member) 49 (nonmember))

First Name _____ MI _____ Last Name _____

Title _____ Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____

What is the attendee's Primary Professional Role? (Choose one)

- | | | | |
|---------------------------|---------------------------------|--------------------------------------|---|
| A ___ Physician | E ___ Social Worker | I ___ Biostatistician/Epidemiologist | M ___ Sales Representative |
| B ___ Pharmacist | F ___ Genetic Counselor | J ___ Researcher | N ___ Marketing Representative |
| C ___ Nurse | G ___ Psychiatrist/Psychologist | K ___ Business Administrator | O ___ Financial Services Representative |
| D ___ Physician Assistant | H ___ Physical Therapist | L ___ Office Manager | P ___ Other _____ |

PAYMENT INFORMATION

Payment is required before the registration can be confirmed.

- Check or Money Order Enclosed
Payable to the American Society of Clinical Oncology
- Wire Transfer
(Please add \$35 processing fee per transfer)
You must include your name and telephone number in the reference section. A copy of the wire transfer confirmation must be enclosed in order to process your registration. SunTrust Bank, Richmond, VA ATTN: Greater Washington Region ABA Routing Number: 061000104 Account Number: 202992829

CREDIT CARD PAYMENTS

American Express Discover MasterCard Visa

Credit Card Number _____

Expiration Date _____

Billing Address _____

Billing City _____ State _____ Zip _____

Cardholder Name _____

Cardholder Signature _____

CHANGE/CANCELLATION POLICY All changes and cancellations must be submitted in writing by May 31, 2010 to qualify for a refund. Refunds will be issued after the Meeting. A \$75 processing fee will be assessed to all refunds. No refunds will be processed for cancellations made after May 31, 2010.

FAX REGISTRATION FORM TO:
ASCO Communications Department **571-366-9537**

FOR OFFICE USE ONLY

QUESTIONS?
Phone: 571-483-1369 E-mail: patientadvocates@asco.org

PAYT _____ CK/WT# _____ AMT _____