

Combined Annual Meeting of CSCTR and MWAFMR

REGISTRATION FORM

April 24-25, 2014 · Renaissance Blackstone Chicago Hotel · CHICAGO, IL



*Please note, registration is not included with the online submission for abstracts. To register for the meeting, please mail or fax this form to CSCTR, 555 E. Wells St., Suite 1100, Milwaukee, WI 53202; fax: (414) 276-3349.

First name _____ Last name _____

Degree(s) _____

Institution _____ Department _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ E-mail _____

I am a member of: CSCTR MWAMFR Non-member ASCI AAP APSA (Check all that apply)

I am a non-member of AFMR and would like a complimentary copy of the *AFMR Journal* which includes the Final Program and copies of all abstracts for this meeting.

PRE-REGISTRATION

Please pre-register me for the 2014 Combined Annual Meeting

- I am a student or trainee. Please pre-register me for the meeting at no charge.
- I will attend the Career Development Workshop on Thursday, April 24, 2014.
- I will attend the Max Miller Lecture in Diabetes Research (Sugar Club Thursday, April 24, 2014 7:00-8:30pm).
- I will attend The Role of Immunology in Health and Disease (Thursday, April 24, 2014 7:00-9:00pm).

Will you be attending the APSA, AAP/ASCI meeting that follow the CSCTR/MWAFMR meeting? (Note: Registration for the CSCTR meeting will allow you access to attend either of these meetings for no charge. You must have your registration badge to gain access. Registration for the APSA or AAP/ASCI meeting will allow you to attend the CSCTR meeting at no charge as well.)

- ___ I wish to attend the APSA meeting
- ___ I wish to attend the AAP/ASCI meeting

Please list any special dietary needs: _____

PAYMENT

- Enclosed is my check for \$25.00 made payable to CSCTR (Central Society for Clinical and Translational Research).
- Please charge \$25.00 to my VISA, MasterCard, American Express or Discover (circle one).

Credit Card Number _____ Expiration Date _____

Name of Card Holder (please print) _____

Signature _____

MAIL OR FAX THIS FORM TO: Central Society for Clinical and Translational Research
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