SYMPOSIUM REGISTRATION FORM

SIXTH ANNUAL CARDIAC NEURODEVELOPMENTAL SYMPOSIUM

June 8-9, 2017

University of Michigan Congenital Heart Center's Palmer Commons
Ann Arbor, Michigan

One form per registrant. PLEASE PRINT

Name____
Last Name First Name Middle Initial Credentials

Mailing Address ____

City ________________________________ State ________ ZIP ______________

Institution____

Specialty _____________________ Position or Title ______________________

Office Phone ( ) _____________________ Alternate Phone ( ) ______________

Fax ( ) ____________________ Email* ______________________________

**E-mail required for confirmation. If you have not received a confirmation email within 7 days of submitting this form, contact cnoc@societyhq.com.*

Do you require special assistance because of a disability or do you have any dietary restrictions? If so, please describe ____________________

If your institution is listed as an Institutional Member, you may register in the appropriate Member category.

Registration Fees

	Through May 8	After May 8	
❑ Member Physician	$350	$400	$ ____________
❑ Member Allied Health (nurses, psychologists, therapists, etc.)	$250	$300	$ ____________
❑ Member Associate In Training (student, intern, resident, fellow, etc.)	$150	$250	$ ____________
❑ Non-Member Physician	$450	$500	$ ____________
❑ Non-Member Allied Health (nurses, psychologists, therapists, etc.)	$350	$400	$ ____________
❑ Non-Members In Training (student, intern, resident, fellow, etc.)	$150	$200	$ ____________

❑ I will attend the Welcome Cocktail Reception on Wednesday, June 7 at the Graduate Hotel. The reception is complimentary for delegates, but you must RSVP.
❑ Welcome Reception Guest Fee #____ @ $50 each. $ ____________
Names of guests: ____

❑ I will attend the Celebration Dinner on Thursday, June 8 at U of M's Museum of Art. The dinner is complimentary for delegates, but you must RSVP.
❑ Celebration Dinner Guest Fee #____ @ $100 each. $ ____________
Names of guests: ____

❑ I have read and agree to the Refund Policy below.

TOTAL AMOUNT DUE $ __________

Concurrent Breakout Sessions

Please choose one Breakout Session for each day.

Thursday, June 8, 10:30 am-12:15 pm
(select one - required to complete registration)
❑ Breakout A: Special Section on Autism and ADHD in Children with CHD
❑ Breakout B: Focus on the Initial Hospital Course in Early Infancy

Friday, June 9, 7:30 am-8:45 am
(select one - required to complete registration)
❑ Breakout A: Aspects of a Program You Might Want to Include
❑ Breakout B: Directions for Advocating Appropriate Neurodevelopmental Care for the Child with CHD

Payment

❑ Check (US currency) payable to CNOC

❑ Credit Card Payment: ❑ VISA ❑ MasterCard ❑ Discover ❑ AMEX

Credit Card No.______________________ Exp. Date ___________ CVV Security Code** _________

Billing Address ______________________________________ Billing Zip Code__________

Signature ____________________________ Printed Name on Card ____________________

**CVV code is the three-digit number on the back of VISA, MC or Discover cards or four-digit number on the front of AMEX cards above the card number.

Refund Policy: 80% refund through 5/7/17; no refunds after 5/7/17. Refunds will be determined by the date the written cancellation request is received. Contact the CNOC headquarters with any questions.

Please return this completed form to:

CNOC | 2209 Dickens Road | Richmond, VA 23230-2005 | Phone (804) 565-6397 | Fax (804) 282-0090 | cnoc@societyhq.com | **www.cardiacneuro.org**