

IPTA 4th Congress on Pediatric Transplantation Registration Form

(One Per Delegate. Information below will be used to create your name badge.)



Delegate:

Surname: _____ First Name: _____ Middle Initial: _____ Degree: _____

Position: _____

Institution: _____

Institution Address: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Telephone (please include country code): _____ Fax: _____

E-mail: _____

Male Female

Birth Date: _____

Primary Specialty/Research Interest: Please provide the demographic information below.

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> A. Bone Marrow/Hematology | <input type="checkbox"/> H. Immunology | <input type="checkbox"/> O. Surgery | <input type="checkbox"/> P. Other: |
| <input type="checkbox"/> B. Cardiology | <input type="checkbox"/> I. Infectious Disease | <input type="checkbox"/> 1. Heart | _____ |
| <input type="checkbox"/> C. Cardiopulmonology | <input type="checkbox"/> J. Internal Medicine | <input type="checkbox"/> 2. Liver | _____ |
| <input type="checkbox"/> D. Critical Care | <input type="checkbox"/> K. Nephrology | <input type="checkbox"/> 3. Lung | _____ |
| <input type="checkbox"/> E. Endocrinology/Diabetes | <input type="checkbox"/> L. Pancreas | <input type="checkbox"/> 4. Pancreas | |
| <input type="checkbox"/> F. Gastroenterology | <input type="checkbox"/> M. Pathology | <input type="checkbox"/> 5. Renal | <input type="checkbox"/> Check here if you are NOT a pediatrician |
| <input type="checkbox"/> G. Hepatology | <input type="checkbox"/> N. Pulmonology | | |

Check the box that best describes you:

- | | |
|--|--|
| <input type="checkbox"/> A. Physician | <input type="checkbox"/> H. Industry/Marketing |
| <input type="checkbox"/> B. Scientist | <input type="checkbox"/> I. Trainee |
| <input type="checkbox"/> C. Surgeon | <input type="checkbox"/> J. Pharmacist |
| <input type="checkbox"/> D. Nurse | <input type="checkbox"/> K. Transplant Coordinator |
| <input type="checkbox"/> E. Lab Technician | <input type="checkbox"/> L. Other |
| <input type="checkbox"/> F. Organ Procurement Personnel | _____ |
| <input type="checkbox"/> G. Professional Association Personnel | _____ |

Affiliation: (check one)

- A. Industry
- B. Government Agency
- C. Private Practice
- D. Research Foundation
- E. Medical School/University
- F. Military
- G. Other: _____

Practice Type:

- A. Research
- B. Clinical

The following information must be supplied if you are registering as a Trainee. Upon contact, the Course Director/Program Director listed below will certify that the Trainee Registrant on this form is a Resident/Trainee of the Institution listed below.

Course Director/Program Director Name: _____

Course Director/Program Director Email Address: _____

Course Director/Program Director Telephone Number: _____

Membership:

- I am an IPTA Member
- I am not a member of IPTA, but I am completing the membership information to the right and will be registering as a member at the reduced registration rates (membership payment due at time of registration).

Membership Type (check one)

- Regular
- Trainee
- Allied Professional
- Emerging Economy (select type below)
- Regular
- Trainee
- Allied Professional

Length of Membership

- | | |
|--------------------------------|--------------------------------|
| 1 year | 2 year |
| <input type="checkbox"/> \$195 | <input type="checkbox"/> \$350 |
| <input type="checkbox"/> \$100 | <input type="checkbox"/> \$180 |
| <input type="checkbox"/> \$100 | <input type="checkbox"/> \$180 |
| <input type="checkbox"/> \$50 | <input type="checkbox"/> \$90 |

