



REGISTRATION FORM

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

Delegate:

Surname/Last Name: _____ First Name: _____ Middle Initial: _____

Degree: _____ Position: _____

Institution: _____

Institution Address: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

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

Email: _____

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"/> Q. 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"/> Check here if you are NOT a pediatrician |
| <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"/> G. Hepatology | <input type="checkbox"/> N. Pulmonology | <input type="checkbox"/> P. Urology | |

Check the box that best describes you: (check one)

- | | |
|--|--|
| <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)

- | |
|---|
| <input type="checkbox"/> A. Industry |
| <input type="checkbox"/> B. Government Agency |
| <input type="checkbox"/> C. Private Practice |
| <input type="checkbox"/> D. Research Foundation |
| <input type="checkbox"/> E. Medical School/University |
| <input type="checkbox"/> F. Military |
| <input type="checkbox"/> G. Other: _____ |

Practice Type: (check one)

- | |
|--------------------------------------|
| <input type="checkbox"/> A. Research |
| <input type="checkbox"/> 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: _____

Email Address and Telephone Number: _____

Course Director/Program Director Telephone Number: _____

Membership: *Join now and save!*

- By completing the membership information to the right, non members can register at reduced registration rates (membership payment due at time of registration).
- When joining IPTA, one-year applicants will have their membership in good standing through Dec. 2009 and two-year applicants will have their membership in good standing through Dec. 2010.

Membership Type (check one) Length of Membership

	1 year	2 year
Regular	<input type="checkbox"/> \$195	<input type="checkbox"/> \$350
Trainee	<input type="checkbox"/> \$100	<input type="checkbox"/> \$180
Allied Professional	<input type="checkbox"/> \$100	<input type="checkbox"/> \$180
Emerging Economy (<i>select type below</i>)	<input type="checkbox"/> \$ 50	<input type="checkbox"/> \$ 90
<input type="checkbox"/> Regular <input type="checkbox"/> Trainee <input type="checkbox"/> Allied Professional		

Registration Form (continued)

Name: _____

Registration Fees:

	On or Before Mar 6	After Mar 6
<input type="checkbox"/> A. Regular Member	US \$450	US \$550
<input type="checkbox"/> B. Trainee Member*	US \$275	US \$325
<input type="checkbox"/> C. Allied Professional Member	US \$275	US \$325
<input type="checkbox"/> D. Emerging Economy Member**	US \$275	US \$325
<input type="checkbox"/> E. Emerging Economy Trainee Member*	US \$275	US \$325
<input type="checkbox"/> F. Emerging Economy Allied Professional Member**	US \$275	US \$325
<input type="checkbox"/> G. Non-member	US \$700	US \$800
<input type="checkbox"/> H. Trainee Non-member*	US \$450	US \$500
<input type="checkbox"/> I. Allied Professional Non-member	US \$450	US \$500
<input type="checkbox"/> J. Emerging Economy Non-member**	US \$450	US \$500
<input type="checkbox"/> K. Emerging Economy Trainee Non Member*	US \$450	US \$500
<input type="checkbox"/> L. Emerging Economy Allied Professional Non Member**	US \$450	US \$500

*In order to receive the trainee rate, you must complete the trainee section listed on page 1 of this registration form.

**In order to be eligible for the Emerging Economy rate, your country must be listed on the IPTA Country List, To view a copy of the IPTA Country List, please visit www.IPTAonline.org.

Delegate Registration Fee: **Total Due US\$** _____

Post Graduate Course: US \$150
 Saturday, April 18 **Total Due US\$** _____

Accompanying person(s): See page 17 for details.

The IPTA Registration Coordinator will contact delegates to request additional accompanying person(s) information i.e. name(s) for badges, etc.

Adults and children from age 12 up
 No. tickets _____ x US \$160 US\$ _____

Children age 5 to 11
 No. tickets _____ x US \$50 US\$ _____

Total Due US\$ _____

Lunch Symposium – Monday, April 20

While this session is included in the delegate registration fee, a ticket will be required to secure lunch and a seat within the session.

I wish to attend I do not wish to attend

Lunches: See page 15 for details.

Sunday, April 19 – Lunch 1 US \$20 US\$ _____

Monday, April 20 – Lunch 2* US \$20 US\$ _____

Tuesday, April 21 – Lunch 3 US \$20 US\$ _____

Total Due US\$ _____

* Do not select if you are attending the Astellas Lunch Symposium.

Parallel Interactive Workshops:

The workshops are included in the registration fee. Within each session, please check the workshop you are most likely to attend. (On-site changes are permitted.)

Sunday, April 19

Workshop Session 1

- ____ Workshop 1: Recurrence of FSGS (Kidney)
- ____ Workshop 2: Management of the Recipient with Thrombophilia
- ____ Workshop 3: Infectious Complications in Developing Countries in Pediatric Solid/Liquid Organ Allograft Recipients

Workshop Session 2

- ____ Workshop 4: Recurrence of HUS
- ____ Workshop 5: Renal Dysfunction in Renal and Non-renal Solid/Liquid Organ Transplant Recipients: Incidence/Etiology/Risk Factors/Prevention/Treatment
- ____ Workshop 6: Social Issues Impacting on Long-term Outcome

Monday, April 20

Workshop Session 3

- ____ Workshop 7: Unique Registry Reports
- ____ Workshop 8: Current Management of PTLD
- ____ Workshop 9: Optimal Approach to Preventing Potential Long-term Complications of Pediatric Solid/Liquid Organ Allograft Recipients

Workshop Session 4

- ____ Workshop 10: What is the Optimal Approach to Drug Monitoring in Pediatric Solid Organ Transplantation?
- ____ Workshop 11: Transplantation of Metabolic Diseases
- ____ Workshop 12: Are There Clinical Models of Tolerance that Currently Exist in Pediatric Solid/Liquid Organ Transplant Recipients?

Social Events:

Note: The Welcome Reception is included in the delegate's registration fee.

I wish to attend:

- Saturday, April 18 Welcome Reception
- Tuesday, April 21 Gala Dinner US \$75
- Vegetarian Kosher **Total Due US\$** _____

Membership **Total Due US\$** _____

If applicable, total from membership section on page 18.

Total Enclosed: **US\$** _____

Payment Information:

Make checks payable to IPTA (US funds drawn on a US bank only) or provide credit card information. Do not send cash!

Charge my Visa MasterCard American Express

Card No. _____

Exp. Date _____

Cardholder's Name _____

Signature _____

When submitting your registration, be sure to include both pages of this registration form. Mail or fax this form to:

IPTA Registration Manager
 15000 Commerce Parkway, Suite C • Mt. Laurel, NJ 08054 USA
 Fax: 001 856-439-0525