

REGISTRATION FORM

Diagnostic Cytopathology Course January 19 - 21, 2008

Send form with payment to:

U. S. & Canadian Academy of Pathology
3643 Walton Way Extension
Augusta, GA, 30909 USA

Telephone: 706/733-7550

Fax: 706/733-8033

Website: www.uscap.org

Please print or type all information. This form may be duplicated as necessary

Name & Degree: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

Primary Practice Venue: University/Medical School Community Hospital Independent Laboratory Other

Registrants and accompanying persons are invited to the reception. Please indicate number who will attend _____



If you will have any special needs while attending this course, please Email details to Kerry Crockett at kerry@uscap.org

Course Fees:

September 1 - November 2: ___ Academy Member \$ 500 ___ Non-Member \$ 575

November 3 - January 15: ___ Academy Member \$ 575 ___ Non-Member \$ 650

January 16 and On Site: ___ Academy Member \$ 650 ___ Non-Member \$ 725

Method of Payment:

Amount Due: _____ Check Enclosed: _____ (Payable to Academy of Pathology)

MasterCard [] VISA [] AmEx [] Expiration Date: _____

Account #: _____

Signature

Date