KY-ACC 14th Annual Scientific Meeting Registration Form

Please complete all sections of this application.

CONTACT INFORMATION

First Name _____ Last Name _____

Credentials _____ License Number (Required for CME/CE) _____

Company/Institution _____ Specialty _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Primary E-Mail Address _____

Preferred First Name on Badge _____

Special Needs(ADA Statement: If you require special physical arrangements to attend this activity, please contact the KY-ACC office at info@kentuckyacc.org.)

Dietary Restriction for Provided Meals:

☐ Gluten-Free ☐ Vegan

☐ Kosher ☐ Vegetarian

If you have any dietary restrictions not listed, please email info@kentuckyacc.org

REGISTRATION FEE

Note: EARLY RATE VALID THROUGH AUGUST 10, 2018.

☐ ACC Physician Member:	$100 (early)	$125 (late)
☐ Physician Non-Member:	$150 (early)	$175 (late
☐ All Other Attendees	$ 40 (early)	$60 (late)

☐ Fellows-In-Training and Students (FREE)

PAYMENT INFORMATION

Balance Due $ _____

☐ Check is enclosed (made payable to KY-ACC).

☐ Please charge this amount $ _____ to this credit card:

☐ AmEx ☐ Visa ☐ MasterCard ☐ Discover

Card Number _____

Expiration Date _____

Name on Card _____

Signature _____ Date _____

Billing Address (if different from above) _____

Kentucky CHAPTER

Return to KY-ACC Headquarters:

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