

# REGISTRATION FORM

## Coronary Artery Disease: Prevention, Detection & Treatment

October 6 – 8, 2008

Bellagio Resort & Spa • Las Vegas, Nevada

Mail or FAX this completed  
registration form to:

Cardiovascular CME  
200 First Street SW, Gonda 6  
ATTN: Deborah Feils  
Rochester, MN 55905

Telephone: 800-283-6296  
or 507-266-0677  
FAX: 507-538-0146  
E-mail: [cvcme@mayo.edu](mailto:cvcme@mayo.edu)

(Please print or type all information. You may duplicate this form for multiple registrations.)

Name \_\_\_\_\_  
First Name Middle Name or Initial Last Name

Degree  MD  PhD  DO  PA  NP  Other \_\_\_\_\_

Institution \_\_\_\_\_

E-mail Address \_\_\_\_\_

Home  Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Country \_\_\_\_\_

Home Telephone (\_\_\_\_\_) \_\_\_\_\_ Business Telephone (\_\_\_\_\_) \_\_\_\_\_

Int'l Telephone (Country code) \_\_\_\_\_ (City code) \_\_\_\_\_ (Phone) \_\_\_\_\_

FAX \_\_\_\_\_

 Please check if you have any special assistance needs or dietary restrictions.  
Please indicate your needs here: \_\_\_\_\_

Vegetarian Meal  Kosher Meal

### PAYMENT

|  | Before<br>Sept. 9, 2008              | After<br>Sept. 9, 2008                  |          |
|--|--------------------------------------|---|----------|
| Physicians (MD/PhD/DO)                       | \$725                                | \$795                                   | \$ _____ |
| Reduced Fee* (Check Appropriate Box)         | \$500                                | \$575                                   | \$ _____ |
| <input type="checkbox"/> Fellow in Training  | <input type="checkbox"/> Resident    | <input type="checkbox"/> Nurse/NP       |          |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Sonographer | <input type="checkbox"/> Emeritus Staff |          |

\* Registrants in the reduced fees category are required to submit with the registration form proof of licensure, a business card, or a letter written on official letterhead and signed by a department supervisor verifying status.

Total Payment Enclosed: \$ \_\_\_\_\_

Full payment must accompany your registration form. Credit card payment must be included for faxed registrations. Check payment will only be accepted with mailed forms. Please use only one method of registration. Do not fax and mail the form in.

Check (make checks payable to Mayo Clinic)  
 Credit Card:  Visa  MasterCard  Discover (Note: American Express is not accepted)

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



Mayo Clinic  
200 First Street SW / GO-06-138SW  
Rochester, Minnesota 55905

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**REGISTER NOW!**

