

REGISTRATION

ENDOVASCULAR SUMMIT 2009

Buenos Aires, Argentina

December 4-5, 2009

Refunds will be given if notification of cancellation is received in writing on or before November 20, 2009. Refunds are subject to a \$50 (USD) processing charge.
No refund will be given to no-shows.

(Please print or type)

Full Name: _____ Designation/Degree: _____

Institution/Company: _____

Address: _____

City: _____ State: _____ Postal Code/Zip: _____

Country: _____ E-mail: _____

Phone: _____ Fax: _____

Program Director's Signature: (required for all physicians in training) _____

PRIMARY MEDICAL SPECIALTY/PROFESSION

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Vascular Surgery | <input type="checkbox"/> Thoracic Surgery | <input type="checkbox"/> Neurology | <input type="checkbox"/> Technician |
| <input type="checkbox"/> Interventional Cardiology | <input type="checkbox"/> Vascular Medicine | <input type="checkbox"/> Physician in Training | <input type="checkbox"/> Industry Professional |
| <input type="checkbox"/> Interventional Radiology | <input type="checkbox"/> Engineer | <input type="checkbox"/> Nurse | <input type="checkbox"/> Other _____ |

REGISTRATION FEES

Physician\$300 (USD)

Other\$ 100 (USD) (Resident, Fellow, Nurse, Technologist, Retired)

Amount Enclosed: \$ _____

PAYMENT INFORMATION

- Registration must be received on or before November 20, 2009 after which on-site registration will be required.
- Please make US bank drawn checks payable to International Society of Endovascular Specialists (ISES) (Tax ID # 86-0725367)

Check Visa MasterCard American Express Discover Card Diners Card

(Please print or type)

Name as it Appears on Card: _____

Card Number: _____

Expiration Date: _____ Verification Code: _____

Authorized Signature: _____ Date: _____

CONFIDENTIALITY AGREEMENT (must be completed by all registrants)


The undersigned, as a registrant, faculty member, or program director for the **ENDOVASCULAR SUMMIT 2008** in Buenos Aires, Argentina December 4-5, 2009, understand that the discussions and materials presented at the meeting are confidential and are intended only for the purposes of peer review and in furtherance of the exchange of information for the improvement of patient care and the reduction of complications. In consideration of my participation in the SUMMIT, I hereby agree to hold in trust and strictest confidence and will not disclose, use, reproduce, publish, distribute, or otherwise disseminate any and all discussions and materials from the SUMMIT outside the SUMMIT and its participants. I further agree not to become involved as a plaintiff's expert in any civil or criminal action involving medical care or treatment that is the subject of critical disclosure during the course of the SUMMIT.

Signature _____ Date _____

THREE EASY WAYS TO REGISTER

MAIL
International Society of
Endovascular Specialists (ISES)
1928 East Highland Avenue
Suite F104-605
Phoenix, Arizona 85016 USA

FAX 1-602-266-6018
 **INTERNATIONAL SOCIETY OF
ENDOVASCULAR SPECIALISTS**
Collaborative. Global. Relevant.
ONLINE
www.endovascularsummit.net

QUESTIONS?

EMAIL
info@endovascularsummit.net
PHONE 1-602-650-1334