

REGISTRATION FORM

Current Concepts in CAH: Classical and Non-Classical

PATIENT EDUCATION CONFERENCE

(for patients with Classical or Non-Classical CAH & health care professionals)

Saturday, November 7, 2015

8:30am-5pm

Hosted by

**The Comprehensive Care Center for Congenital Adrenal Hyperplasia at
 New York Presbyterian/Weill Cornell Medical Center**

Name: _____

Address: _____

Day Phone #: _____ Email: _____

***Please note: There are no babysitting accommodations available for this conference.**

Registration deadline October 23, 2015

YES, please reserve _____ spaces for the 2015 Conference.

Conference Attendance Fees: \$20/person \$25/professional \$30/couple \$40/family

I am/We are participating as a/an: Parent Other Relative Affected Adult Medical Prof.

Please list all conference participants:

Name:	Relationship to YOU: (Spouse, Parent etc.)	CAH Type (SWCAH, Carrier, Unaffected, etc.):
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes, I would like to purchase a [CARES T-shirt](#) (special conference discount price of **\$10 each**)

Note quantity next to size: **Adult:** __SM __Med. __LG __XLG __XXLG **Youth:** __SM __Med. __LG

PAYMENT **BY CREDIT CARD:** Select one **VISA** **M/C** **AMEX**

Name on Card: _____ Amount (USD): \$ _____

Card #: _____ Expiration Date: ___/___ Security Code: _____

Billing Address: _____

Signature: _____

FAX form with credit card payment to **908-686-2019** or **MAIL** form with payment to: **CARES Foundation, Inc., CARES Conference, 2414 Morris Ave., Suite 110, Union, NJ 07083** Make checks payable to **CARES Foundation, Inc.** **QUESTIONS?** Call **866-227-3737** or email: conference@caresfoundation.org.

REFUND POLICY: Refund requests must be submitted in writing by fax or email no later than October 30, 2015. Refunds will be issued 2-3 weeks after the event.