

AMERICAN CLINICAL MAGNETOENCEPHALOGRAPHY SOCIETY (ACMEGS)

2019 COURSE & MEETING REGISTRATION FORM

| (Please type or print clearly.) | | |
|---|--------------------|------------------|
| ACMEGS Member ID # (optional) | | |
| Last (Family) Name F | First (Given) Name | Middle Initial |
| | stitution | |
| Mailing Address | | |
| | | _Zip/Postal Code |
| Phone | _Fax | |
| Email | Specialty | |
| SPECIAL NEEDS | | |
| $\hfill\square$ I have an allergy-related or religious dietary restriction, as follows: | | |

I require a physical accommodation, as follows:

PRIVACY/OPT-INS

□ I wish to be included on the delegate list provided to supporters. □ I wish to be included on any published delegate list including programs, mobile apps, etc.

| | Center-Designated Members* AND Individual Members from Member Centers* | Associate Members* | Individual Members* | Non-Members | | |
|---|--|-----------------------|------------------------|---|--|--|
| Tuesday, February 5 - Wednesday, February 6, 2019 | | | | | | |
| Course | □ \$125 | □ \$125 | □ \$250 | □ \$250 | | |
| Thursday, February 7, 2019 | | | | | | |
| Meeting | □ \$75 | □ \$75 | □ \$150 | \$150 (including dinner) \$75 (without dinner) | | |

*Dues current through 12/31/2018 or later

Total Amount Due: ____

PAYMENT INFORMATION

Company Check – Make check payable to American Clinical Magnetoencephalography Society (in US Dollars, drawn on a US bank)

| □ Credit Card (check one): □ VISA □ MasterCard | | |
|--|-----------------|--|
| Please invoice me. | | |
| Credit Card Number | Expiration Date | |
| Card Holder Name | | |
| Authorized Signature | Date | |

Registrations will not be processed without payment and signature.

Signature of Agreement: I understand that the event registration rate listed above will be charged to the credit card I have listed. I understand further that all registration charges must be paid in full upon completion of this form. If registration is not paid for in full at time of event, I may be asked to provide payment upon arrival at the meeting.

Cancellation Policy. Refund requests must be submitted in writing to ACMEGS prior to January 31, 2019. A \$20 processing fee will be charged for all refunds. We regret refunds will not be guaranteed for requests postmarked or received after January 31, 2019.

Waiver: Submission of this registration form and payment of associated fee serves as agreement by the delegate to release the American Clinical Magnetoencephalography Society, Caesar's Palance, their respective agents, servants, employees, representatives, successors, and assigns, from any and against all claims, demands, causes of action, damages, costs, and expenses, including attorneys' fees, for injury to person or damage to property arising out of attendance. In addition, the delegate hereby grants permission to use his/her likeness in a photograph or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration, agreeing that these materials will become the property of ACMEGS which has the right to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing its programs or for any other lawful purpose. Additionally, the delegate waives any right to royalties or other compensation arising or related to the use of the photograph.

PLEASE RETURN THIS REGISTRATION FORM WITH REQUIRED PAYMENT TO

American Clinical Magnetoencephalography Society, Attn: Meetings Department • 555 E. Wells Street, Suite 1100 • Milwaukee, WI 53202 Fax: (414) 276-3349 • E-mail: info@acmegs.org