

Registration Form

Indicate your profession:

Physician Fellow Social Worker
 Nurse Dietitian PA
 Advanced Practice RN
 Other _____

Have you attended before? Yes No

IMPORTANT: PLEASE SIGN UP FOR THE SESSIONS OF YOUR CHOICE.

This is required for room sizes/seating arrangements.
(See pages 7-14 for session numbers)

SUNDAY, MARCH 4

General Session:	0	9	A
10:45am - 12:15pm:	1	0	
Luncheon Session:	1	2	
Poster Session:	0	1	
Pediatric Poster Session:	0	1	
2:00 - 4:00pm:	0	2	
4:15 - 5:30pm:	0	4	

MONDAY, MARCH 5

Fellows Symposium:			
Slide Forums:	0	9	
9:00 - 10:30am:	0	9	
10:45am - 12:00pm:	1	0	
Luncheon Session:	1	2	
Poster Session:	0	1	
Pediatric Poster Session:	0	1	
2:00 - 4:00pm:	0	2	
4:15 - 5:30pm:	0	4	

TUESDAY, MARCH 6

8:00 - 10:00am:	0	8	
10:15am - 12:00pm:	1	0	

COURSE FEES: Please check all that apply

Preconference Fees: \$175 USD - Fellows
 \$175 USD - Nurses, Dietitians, Social Workers, Other Health Professions
 \$250 USD - Physicians

Please select the Session you will be attending • March 3, 2018:

Peritoneal Dialysis Home Hemodialysis Symposium
 Fundamentals of Extracorporeal Therapy The Fundamentals of Dialysis in Children

38th Annual Dialysis Conference Fees • Sunday, March 4 - Tuesday, March 6, 2018

\$549 USD - Early fee - Paid by January 22, 2018 (midnight deadline)
 \$699 USD - Regular fee - Paid by February 22, 2018 (midnight deadline)
 \$799 USD - Late fee - February 23 through conference dates and on-site

ISN Member? Yes No **ISPD Member?** Yes No **ISHD Member?** Yes No

Note: \$10 discount for ISPD/ISHD/ISN members--only applies to the 38th Annual Dialysis Conference (March 4-6).
Must register by January 22, 2018 to receive discount

TOTAL FEES _____

First Name _____ Last Name(Surname) _____
(As you would like it to appear on nametag)

Degree(s) _____

Email Address _____

Emergency Contact _____

Emergency Contact Phone Number _____

Institutional Affiliation _____

Preferred Mailing Address _____

City _____ State _____

Zip/Postal Code _____ Country _____

Business Phone Number _____ FAX Number _____

Please indicate any special arrangement requests or dietary needs and we will attempt to accommodate your request:

SEND COMPLETED FORM TO:

Dialysis Conference
Office of Continuing Medical Education &
Physician Lifelong Learning
1 Hospital Drive, DC018.00
Columbia, Missouri 65212 USA

Questions?

Phone: (573) 882-4105 • Fax: (573) 882-5666
Email: dialysis@health.missouri.edu
Website: www.annualdialysisconference.org

Payment should accompany form.

Confirmation/Receipt will be mailed within 2 weeks after payment is received.

Check Enclosed (X only if payment is by check, payable to the University of Missouri.)

Credit Card Payment: Visa MasterCard Discover American Express
(On your credit card statement, the conference registration fee will show as being paid to the University of Missouri)

Please PRINT name as it appears on card

Cardholder's mailing address if DIFFERENT from above

Signature _____

Account Number _____ Expiration Date _____