

Regional Course Registration

AS|DS

2010 Registration Application

EACH COURSE IS LIMITED TO 50 PARTICIPANTS – APPLY TODAY!

Please complete the information requested on this application and return it with your full payment to the address indicated. Note that this is an application for registration. Participation will be confirmed on a first-come, first-served basis, upon verification of prerequisites and space availability.

PLEASE PRINT

Dermatologic Surgery Board Certification Year: _____

Residency Training Year: _____ Location: _____

Please enclose a copy of your medical license.

Institution: _____

Describe your current medical practice: _____

CONTACT INFORMATION

FIRST _____ MI _____ LAST _____

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

EMAIL _____

SELECT DATE & LOCATION

Mastery of Lasers:

- New York, NY
March 27-28
- Miami, FL
Dec. 4-5

Art & Science of Fillers & Injectables

- Atlanta, GA
April 17-18
- Raleigh Durham, NC
June 12-13
- Boston, MA
Sept. 11-12
- San Francisco, CA
Nov. 20-21

REGISTRATION CATEGORY

- Residents/Fellows – R..... \$200
- ASDS Members – M \$725
- Non-Member Dermatologic Surgeons – B..... \$900

The registration fee includes continental breakfasts, breaks and lunches. Full payment is due upon submission of the application

PREREQUISITES FOR PARTICIPATION

Physicians who wish to participate in procedural courses sponsored by the ASDS will be required to demonstrate the following prerequisites:

1. Residency training and/or Board Certification by the American Board of Dermatology or the American Osteopathic Board of Dermatology
2. Current state medical license (or international equivalency)
3. Medical practice which is focused on dermatologic and/or cosmetic surgery and provides, on a regular basis, treatment and procedures for rejuvenation of the aging face

Payment Information

You may pay by **check** or **credit card**. Please indicate below:

Check Visa MasterCard American Express

CREDIT CARD # _____ EXP DATE _____

NAME ON CARD (PRINT) _____

AUTHORIZED SIGNATURE _____

TOTAL AMOUNT: \$

BY CHECK

Send checks payable to:

ASDS

3621 Solutions Center
Chicago, IL 60677-3006

BY CREDIT CARD

Fax completed form to **847-956-0999**