

Registration: 39th Annual Radiation Oncology Clinical Research Seminar

February 27-28, 2009

Registrant's Name _____ Degree _____

E-mail address _____

Specialty _____ Institution _____

Address _____

City _____ State _____ Zip _____

MEETING FEE Physician *Resident/Med. Student/ARNP/PA

Registration **\$350** **\$150**

Amount Paid:

I plan to attend: Friday luncheon (included) yes no Friday evening reception (included) yes no

Return completed form with check (payable to **University of Florida**) to

Continuing Medical Education, Univ. of Florida, PO Box 100233, Gainesville FL 32610-0233

IF PAYING BY CREDIT CARD, THE INFORMATION MUST EITHER BE SUBMITTED ONLINE OR MAILED TO THE CME OFFICE. IF MAILING, COMPLETE THIS SECTION:

Circle one: MC Visa Name on account _____ Expiration date _____

Card number _____ Signature _____

*Please provide a statement signed by the department chairman or director confirming your status.