

Registration: 37th Annual Radiation Oncology Clinical Research Seminar
February 23-24, 2007

Registrant's Name _____ Degree _____

E-mail address _____

Specialty _____ Institution _____

Address _____

City _____ State _____ Zip _____

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

Registration **\$325** **\$100**

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|--------------|
| 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: 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.