

15th Annual Meeting

REGISTRATION FORM



ANNUAL MEETING REGISTRATION FORM

Please register early for the 15th Annual Meeting. The Annual Meeting registration fee covers all scientific sessions and social program *except* the Pre-Meeting Courses, which are additional registration fees.

Registration Fees - Annual Meeting	By 12/31/03	After 12/31/03	TOTAL
Physician-Member <i>(Must be a member of NASBS, or other _____ Skull Base Society)</i>	\$500.00	\$600.00	\$ _____
Physician-Non-Member	\$675.00	\$775.00	\$ _____
Resident/Fellow* <i>(Requires signature below)</i>	\$275.00*	\$350.00*	\$ _____
Allied Health	\$300.00	\$350.00	\$ _____
Accompanying Person <i>(Includes Social Program, does not attend meetings)</i>	\$285.00	\$385.00	\$ _____

Registration Fees - Pre-Meeting Courses

Please note: Enrollment in the following courses is limited. Register early to insure a space. Preference will be given to those also registered for the Annual Meeting.

Hands-On Practical Course <i>(Wed-Fri, Feb 11-13)</i>	\$950.00	\$1,000.00	\$ _____
Hands-On Practical Course <i>(Wed-Fri, Feb 11-13)*</i> Resident/Fellow*	\$850.00*	\$900.00*	\$ _____
Endoscopic Course: Hands-on Training <i>(Fri, Feb 13)</i>	\$300.00	\$350.00	\$ _____
Endoscopic Course: Hands-on Training <i>(Fri, Feb 13)*</i> Resident/Fellow*	\$200.00*	\$250.00*	\$ _____
Reconstruction Course: Hands-on Training <i>(Fri, Feb 13)</i>	\$300.00	\$350.00	\$ _____
Reconstruction Course: Hands-on Training <i>(Fri, Feb 13)*</i> Resident/Fellow*	\$200.00*	\$250.00*	\$ _____

Course for Nurses/Allied Health *(Mon, Feb 16)* - No Additional Registration Fee Required. Enrollment is limited.

Registrant's Name _____

Address _____

Address _____

City _____ State _____ Country _____ Zip _____

Phone _____ Fax _____ Email _____

*Program Director's Signature Required for Residents/Fellows only _____

Accompanying Person Name _____

Registration fees may be paid with a personal or institutional check in US dollars payable to the NASBS or by credit card.

Please specify any special needs or dietary requirements: _____

Registration to paid by: Check MasterCard VISA AMEX

Name on Credit Card (please print) _____

Card Number _____ Exp Date _____

Credit card billing ZIP code _____ Signature _____

Please mail payment and completed registration form to:

North American Skull Base Society • Lockbox #4728 • PO Box 85080 • Richmond, VA 23285-4728

Fax: 703-435-4390 • Or visit the NASBS website at www.nasbs.org