Practice Management Conference - *2018*

REGISTRATION FORM

Please complete the registration form below and return with your registration fee to:

Illinois Dermatological Society
10 W. Phillip Rd., Suite 120, Vernon Hills, IL 60061-1730

If paying by credit card, you may fax your form to: 847/680-1682

You may complete this form on your computer and print it out, or fill out by hand.

Sponsoring Dermatologist's name ➜ ***(MUST be included)***	
Office Address ➜	
Office Contact Information ➜	***Phone:*** ***Fax:*** ***Email:***

REGISTRATION & FEES

If you need more space, copy this form and attach. Individual fees may be combined into one check.
IDS Member/Staff = $75 Non-member physician/staff = $150 Resident/fellow = $0

Attendee's Name	**Status *(check one)***	**Registration fee**
______________________	❑ IDS member/staff ❑ Resident/Fellow ❑ Non-member physician/staff	$ __________
______________________	❑ IDS member/staff ❑ Resident/Fellow ❑ Non-member physician/staff	__________
______________________	❑ IDS member/staff ❑ Resident/Fellow ❑ Non-member physician/staff	__________
______________________	❑ IDS member/staff ❑ Resident/Fellow ❑ Non-member physician/staff	__________

Total registration fee enclosed . . . . *Make your check payable to the "Illinois Dermatological Society"*	**$** ________________ *Form of payment:* ☐ Check ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date ☐☐ / ☐☐

Security Code (3 or 4 digits) ☐☐☐☐

Signature: ____

Name on card: ____

Billing address (if different than above): ____