CROSS-CULTURAL HEALTH CARE CONFERENCE V: COLLABORATIVE AND MULTIDISCIPLINARY INTERVENTIONS

FEBRUARY 17-18, 2017

First Name_____ Last Name _____ Degree_____

Name on Badge _____ Job Title _____

Organization _____ Address _____

City _____ State_____ Zip Code _____

Daytime Phone_____ Fax_____ Email: _____

ADA – Do you have any special needs ? Dietary and other? ☐ NO (please specify)_____

EARLY BIRD REGISTRATION FEES IF PAYMENT RECEIVED BEFORE OCTOBER 31, 2016			
	2 DAY CONFERENCE RATE	**1 DAY CONFERENCE RATE**	**CME (optional)**
PROFESSIONAL: (Please check profession) MD ☐ PhD ☐ Other ☐	$275	$250	$35
STUDENT/RESIDENT (Student ID required)	$125	$100	$35

REGISTRATION FEES IF PAYMENT RECEIVED AFTER OCTOBER 31, 2016			
	2 DAY CONFERENCE RATE	**1 DAY CONFERENCE RATE**	**CME (opt.)**
PROFESSIONAL: (Please check profession) MD ☐ PhD ☐ Faculty ☐	$325	$300	$35
STUDENT RESIDENT (Student ID required)	$175	$150	$35

Please indicate what days you wish to attend: ☐ **Both days** ☐ **Friday only 2/17/17** ☐ **Saturday only 2/18/17**

PHYSICIANS – CME APPLICATION (up to 16 CME CREDITS)
☐Yes, I would like CME Credits (add $35.00 to registration fee)

License Number (for CME purposes) _____

PAYMENT (Please mail registration form and payment to Kenlynn Nelson, Manager, UH Conference & Event Services, 1951 East West Road, #202, Honolulu, HI 96822 or fax to: (808) 586-3022

This form MUST be accompanied by the appropriate conference registration fee paid by check or credit card. Please use one registration form per participant. Make checks payable to: **University of Hawaii**. The security of your personal information is extremely important to us. We will never sell or rent your personal information to any third parties under any circumstances. **Cancellations:** Requests for refunds must be received by **November 1, 2016, with a $50 processing fee**. No refunds will be made thereafter. Email cancellation request to kenlynn8@hawaii.edu or fax to (808) 586-3022.

☐ **CHECK Enclosed (in U.S. $) Check # _____ Amount: $_____**

☐ **I hereby authorize University of Hawaii the use of my credit card account (Please check one):**
- ☐ **Visa**
- ☐ **Mastercard**

Credit Card # _____ Expir Date: _____ 3 digit # _____(back of card)

_____ _____ $_____
Print Name **Signature** **Amount to be charged**