

Registration Form
Pre-Registration Deadline January 19, 2018

Title: Dr. Prof. Mr. Mrs. Ms. Miss

First Name * _____ Last Name* _____ Degree* _____

Institution, Company or Organization* _____

Department _____

Address* _____

City* _____ State* _____ Zipcode* _____

Phone Number* _____ Mobile Number _____

Email:* _____

*Required

Registration Category & Pre-Registration Discount Fees

Physician	\$175.00	Resident/Fellow	\$35.00
Pharmacist	\$175.00	UTHSCSA & SAMMC	\$70.00
Physician Assistant/Nurse Practitioner	\$175.00	Industry Representative	\$375.00
Nurse	\$95.00	Student	\$25.00
		Other _____	\$70.00

Method of Payment

Check: payable to UTHSCSA #153478, **mail to:** Rich Markow
UT Health Cancer Center
7979 Wurzbach Rd., MC 8224
San Antonio, TX 78229

AMEX MasterCard Visa Discover

Credit Card Number _____

Cardholder Name _____

Exp Date (MM/YYYY) _____ CCV _____

Address _____ Zip Code _____

Signature _____

I authorize UT Health to charge the credit card indicated on this registration form. This payment authorization is for the registration described above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to this registration. After placing this registration order, any dispute to the charge must be done through UT Health and it is UT Health's sole discretion whether to make any adjustments to the payment.

Cancellation Policy. You must contact us no later than January 19, 2018 to cancel your registration. For cancellations made by January 19, 2018, your registration fee will be refunded less a \$25 cancellation fee. No refunds after January 19, 2018.

For Registration inquiries or requests, contact us at 210-450-1550 or panao@uthscsa.edu. Website <https://ctrc.eventsair.com/new-agents/panao2018>.