IAPAM
INTERNATIONAL ASSOCIATION FOR PHYSICIANS IN AESTHETIC MEDICINE

Aesthetic Medicine Symposium

Please complete and Fax (toll-free) to: 1-866-284-9318

SYMPOSIUM DATE:	**HOW DID YOU HEAR ABOUT THE SYMPOSIUM ?**

NAME ***(As you would like it shown on the Certificate)*****:**
LAST: **FIRST:** **MIDDLE INITIAL:** **MEDICAL DESIGNATION:**

MAILING ADDRESS: ☐ **Home** ☐ **Practice**
STREET: **CITY:** **STATE:** **ZIP CODE:**

CELL PHONE NUMBER:	**EMAIL ADDRESS:**

PRACTICE NAME:

PRACTICE ADDRESS (if not entered above):
STREET: **CITY:** **STATE:** **ZIP CODE:**

PRACTICE TELEPHONE:	**PRACTICE FAX:**

SPECIALITY(IES)/SUBSPECIALITY:	**MEDICAL SOCIETY/ORGANIZATIONS MEMBERSHIPS:**

MEDICAL LICENSE #: **STATE/JURISTICTION:** **DATE ISSUED:** **DATE EXPIRED:**

MEDICAL SCHOOL: **LOCATION OF SCHOOL (State or Country if not U.S):** **YEAR GRADUATED:**

SYMPOSIUM OPTIONS (Physician):

☐ **$2,195** ***IAPAM Accredited Member*** **Early Registration Discount for 2 Day Symposium (a member saving of $1,100)**

☐ **$295 - I want to join the IAPAM as an** ***Accredited Member*** **today to get the (above) member Symposium price**

☐ **$595 Attend the Medical Weight Management Program (Friday, must be attending 2 day Symposium)**

Optional - Choose for Monday:

☐ **$ 595 Business Track "Aesthetic Practice Startup Workshop" ($995 non-members)**

ADDITIONAL ATTENDEES (if applicable):

☐ **$ 1,595/ea for 2 Day Symposium QTY: ____**

☐ **$ 595 if additional attendee is ONLY attending Medical Weight Management Program (Friday) QTY: ____**

☐ **$ 395/ea – if additional attendee is ALSO attending Saturday/Sunday Aesthetic Medicine Symposium QTY: ____**

Optional - Choose for Monday:

☐ **$ 595/ea Optional 3rd Day Business Track "Aesthetic Practice Startup Workshop" (Monday 8am-2:30pm) QTY: ____**

ADDITIONAL ATTENDEE(s): NAME, DESIGNATION & E-MAIL (need for certificate, name badge, & confirmation email):

PAYMENT TYPE: **Credit Card:** ☐ **AMEX** ☐ **Visa** ☐ **MasterCard**

CARD NUMBER:	**EXPIRY DATE:** / **(mm/yr)**	**CARD VERIFICATION NUMBER:** (3 digit number on back of card after the card number)

NAME AS IT APPEARS ON CREDIT CARD:

*** PLEASE NOTE: YOU WILL RECEIVE A CHARGE ON YOUR CREDIT CARD STATEMENT FROM: IAPAM**

CANCELLATION POLICY:
Once your payment has been received and processed, you will receive an e-mail confirmation. If for some reason you cannot attend the symposium you must give at least 72 hours notice to receive a full credit for a future symposium, no refunds will be given. If for some unforeseen the symposium is cancelled, you will receive a full refund limited to the registration fees already paid. The IAPAM is not responsible for non-refundable airline tickets, related travel costs, hotel accommodations purchased, or any other out of pocket expense you may incur. Symposium locations, agendas, and speakers are subject to change.

I hereby affirm that the information provided on this application is true, current, and correct. This symposium attendance is limited to active licensed physicians (i.e. MD, DO) in good standing. We reserve the right to refuse registration from any attendee. You hereby release all persons and entities, including the IAPAM, their employees and agents, from any liability they might incur for their acts, omissions, and/or communications arising from this application, to the extent those acts, omissions and/or communications are protected by state, federal and/or international law. I understand and agree to the terms of the IAPAM's Privacy Policy that can be found on the IAPAM's website. I herby authorize the IAPAM and PCA to charge my credit card that I have listed above, for the amounts indicated. The IAPAM is not responsible for additional credit card charges your bank may charge.

SIGNATURE:_____**DATE:**_____

Rev. 120515