ADVANCE REGISTRATION FORM

FOR OFFICE USE ONLY • Group ID Code ____________

32nd Annual San Antonio Breast Cancer Symposium • December 9-13, 2009

COMPLETE ALL SECTIONS FULLY • ONE INDIVIDUAL PER FORM

CIRCLE ONE
Dr. Prof. Mr.
Mrs. Ms. Miss

LAST NAME **FIRST NAME** **MI**

SPOUSE (If attending): (Access to exhibits only)
SPOUSE LAST NAME **SPOUSE FIRST NAME** **MI**

EMERGENCY CONTACT NAME & PHONE NUMBER

E-MAIL ADDRESS

DEGREE(s) (or Equivalent)
MD DO PhD
PharmD RN Other ______

INSTITUTION, COMPANY, or ORGANIZATION NAME

DEPARTMENT

ADDRESS 1

ADDRESS 2 **CITY**

STATE or PROVINCE **COUNTRY (if not US)**

ZIP OR POSTAL CODE **TELEPHONE NUMBER, WITH COUNTRY & CITY CODES** **FAX NUMBER, WITH COUNTRY & CITY CODES**

PRIMARY PROFESSIONAL FOCUS (**Check ONE only**):
- ☐ Medical Practice/Clinical Research
- ☐ Basic Research
- ☐ Epidemiology
- ☐ Prevention
- ☐ Translational Research
- ☐ Other

PRIMARY PROFESSIONAL OCCUPATION (**Check ONE only**):

Medical Practice/Clinical Research
- ☐ 01 Medical Oncologist
- ☐ 02 Surgical Oncologist
- ☐ 03 Radiation Oncologist
- ☐ 04 General Surgeon
- ☐ 05 Gynecologic Oncologist
- ☐ 06 Pathologist
- ☐ 07 Radiologist
- ☐ 08 Clinical Geneticist
- ☐ 09 Oncology Nurse
- ☐ 10 Research Nurse
- ☐ 11 Data Manager
- ☐ 12 Other Physician
- ☐ 13 Other Nurse

Basic Research
- ☐ 20 Laboratory Scientist
- ☐ 21 Statistician
- ☐ 22 Epidemiologist
- ☐ 23 Postdoctoral Fellow
- ☐ 24 Research Assistant
- ☐ 25 Student

Industry
- ☐ 30 Corporate Research
- ☐ 31 Marketing/Sales
- ☐ 32 Industry Nurse
- ☐ 33 Pharmaceutical Rep
- ☐ 34 Industry PR
- ☐ 35 Other Industry

Other Profession
- ☐ 40 Patient Advocate
- ☐ 41 Administrator
- ☐ 42 Other PR
- ☐ 43 Press/Media
- ☐ 44 Medical Writer
- ☐ 45 Pharmacist
- ☐ 46 Other Occupation

REGISTRATION CATEGORY:

	(Check One) Until 10/31/09	Beginning 11/1/09
Regular Registration	RRA ☐ $ 400	$575
Regular Registration: AACR members	CRA ☐ $ 350	$500
AACR member ID: ______		
Postdoctoral MD in training	PMA ☐ $ 65	$75
Postdoctoral PhD in training	PPA ☐ $ 65	$75
Student (Valid ID required w/registration)	SU ☐ $ 0	$0
UTHSCSA & BCM staff & faculty (Valid ID required w/registration)	ST ☐ $ 0	$0
Patient Advocate* (Must provide name of the organization you are representing)	PAA ☐ $ 65	$75

Advocate Organization ______________________

*Contact **Alamo Breast Cancer Foundation** PO Box 780067, San Antonio TX 78278, for Advocate Program information and possible financial assistance • E-mail **sandisues@sbcglobal.net**

Are you part of an official Group Registration? ☐ No ☐ Yes

(Provide Group ID Code here.) ______________________

REFUNDS: Cancellations received on or before November 17, 2009 will be refunded less processing fees. Cancellations received after November 17, 2009 are non-refundable. Brinker Award Dinner tickets are not refundable after November 17, 2009.

Mail to:
SABCS Registration c/o AMBASSADORS
240 Peachtree St. 22-S-10
Atlanta, GA 30303

OR fax to:
888-267-0945
or 949-219-2317
(International)

Registration inquiries may be directed to: **sabcsreg@ambassadors.com**
or by phone 877-517-3040 (US & Canada) or 404-584-7458 x2651 (International).

	How Many	Each Ticket	Total
Brinker Awards Dinner Thursday 12/10	AD ☐	$45	$

☐ **I have special dietary requirements.**
☐ Kosher ☐ Low-sodium ☐ Vegetarian ☐ Diabetic

Total for Registration Fee .... $ ______
Total for Brinker Award Dinner Meal Tickets. . . . $ ______
Wire Transfer Fee $25 (if applicable)........... $ ______
TOTAL AMOUNT DUE.................. $ ______

Payment must be in US Currency. • Checks must be drawn on US bank.

PAYMENT TYPE: (No Purchase Orders.)

☐ Payment is being made by Group Contact.
☐ Check/Money Order/Draft.
(Make payable to UTHSCSA-CME#127258)
Wire Transfer, your bank to ours. Add $25 to the total for transfer fees.

Instructions for wire transfer will be sent to you by E-mail after your registration is received by SABCS.

☐ AMEX ☐ MasterCard ☐ Visa ☐ Discover

Credit Card Number ______________________

Exp Date (MM/YY) ______________________

Cardholder Name ______________________

Signature ______________________

☐ **Pursuant to the Americans With Disability Act, I require specific aids or services during my visit.** ☐ Audio ☐ Visual ☐ Mobile

THIS PAGE MAY BE PHOTO COPIED