

Registration Form

Complete All Sections Fully. One Individual Per Form. To register online, visit www.sabcs.org/virtualregistration

DEADLINE: DECEMBER 1, 2020

Name (Please print) _____

DATA PROCESSING CONSENT

Why we ask for your consent

We are committed to protecting the privacy of all personal data or photos taken during the event. The following statements describe what we are doing with your data and how long we store it so that you are fully informed prior to submitting your personal data and photos taken during the event. Your active participation in this process is your explicit consent to the processing, analysis and reporting of your freely given personal data for the purposes of this ongoing event. Images may be used in print publications, online publications, websites and social media. By giving your consent you acknowledge that you are providing personal data, including sensitive personal data as defined under the General Data Protection Regulation (GDPR) for the Lawful Basis of registration, participation, payment and communication for future meetings and related information.

Data Controller Contact

Symposia Office
UT Health San Antonio

Mays Cancer Center
7979 Wurzbach Rd., MC 8224
San Antonio, TX 78229
210-450-1550

Data Protection Officer

Michael Schnabel
UT Health San Antonio

Why are we processing your personal data?

We ask for your personal data to facilitate registration, participation, payment and communication for future meetings and related information. Images may be used in print publications, online publications, websites and social media.

Third Parties that will have access to your personal data

Your personal data will only be viewed and processed by the Symposia Office and its affiliates for registration, participation, payment and communication for future meetings and related information. Images may be used in print publications, online publications, websites and social media.

How long will we store your personal data?

As a participant of this meeting, your personal data will be retained indefinitely for purposes of communication for future meetings and related information.

The right to withdraw your consent

You retain the right to withdraw consent of your personal data at any time. By withdrawing your consent your registration will not be submitted or processed. If consent is withdrawn prior to this event it will result in cancellation of your registration and the cancellation policy will apply. If consent is withdrawn, you will not receive any communications for future meetings or related information. Please contact us at sabcs@uthscsa.edu with any inquiries you may have.

I give consent I decline giving consent to this registration

By checking **I give consent**, you acknowledge that you are providing personal data, including sensitive personal data as defined under the General Data Protection Regulation (GDPR) for the Lawful Basis of registering for and participating in SABCS and/or SABCS related programs.

By checking **I decline giving consent to this registration**, you will not be able to register for this event and will not receive any communication for future Symposia or SABCS related information. Consent must be given in order to register.

If you would like to give consent in order to register and attend the Virtual 2020 San Antonio Breast Cancer Symposium only, select **I give consent** and notify us at sabcs@uthscsa.edu as to the date you wish to withdraw consent (this date must be post-symposium). Please note, if you do not notify SABCS with an end date for consent, you will remain in the SABCS database and continue to receive communications for future SABCS and/or SABCS related information.

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REGISTRATION INFORMATION

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

Primary Degree:

BS BSc BSN Chb DO Dr Med DSc MBBS Mb ChB MD
 MD MPH MD MSc MD PhD NP PA PharmD PhD RN Other _____

First/Given Name* _____ Last/Family Name* _____

Institution, Company or Organization* _____

Department* _____

Address* _____

City* _____ State of Province* _____

Country* _____ Zip or Postal Code* _____

Phone Number* _____ Mobile Number* _____

Email: Registration Confirmation will be sent to this email* _____

Email: Evaluation (CME) will be sent to this email* _____

Twitter handle _____

National Provider Identifier (NPI) - If US MD _____

Go to <http://npiregistry.cms.hhs.gov> to retrieve NPI.

What is one question you would like answered at the 2020 SABCS?

I will be claiming CME Yes No
Primary degree must be MD or DO equivalent to receive CME Certificate of Credit.

Please include me in the mailing list for printed SABCS information Yes No

PLEASE BE SURE TO SCAN OR FAX ALL FOUR PAGES OF THIS FORM WHEN SENDING

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Information concerning race or ethnic background, gender and age enable SABCS to ensure that it is serving all participants of its diverse community. (This information is voluntary.)

<p>RACE OR ETHNIC BACKGROUND (CHECK ONLY ONE)</p> <p> <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other (please specify) _____ </p>				
<p>GENDER</p> <p> <input type="checkbox"/> Male <input type="checkbox"/> Female </p>				
<p>AGE GROUP (CHECK ONLY ONE)</p> <p> <input type="checkbox"/> 18-30 years old <input type="checkbox"/> 31-45 years old <input type="checkbox"/> 46-55 years old <input type="checkbox"/> 56-65 years old <input type="checkbox"/> 66 years old and over </p>				

PRIMARY PROFESSIONAL FOCUS & OCCUPATION CATEGORIES

<p>WORK SETTING* (CHECK ONE)</p> <p> <input type="checkbox"/> Academia <input type="checkbox"/> Foundation/Advocacy Organization <input type="checkbox"/> Government <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Industry/Private Sector <input type="checkbox"/> Private Practice <input type="checkbox"/> Other _____ </p>									
<p>FOCUS* (CHECK ONE)</p> <p> <input type="checkbox"/> Basic Research <input type="checkbox"/> Clinical Research <input type="checkbox"/> Epidemiology <input type="checkbox"/> Medical Practice <input type="checkbox"/> Prevention <input type="checkbox"/> Translational Research <input type="checkbox"/> Other_____ </p>									
<p>OCCUPATION* (CHECK ONE)</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p>Practice/Clinical Research</p> <p> <input type="checkbox"/> Trainee (Clinical Fellow) <input type="checkbox"/> Data Manager <input type="checkbox"/> Gynecologic Oncologist <input type="checkbox"/> Medical Oncologist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Oncology Nurse <input type="checkbox"/> Other Nurse <input type="checkbox"/> Pathologist </p> </td> <td style="vertical-align: top;"> <p> <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Physician Scientist <input type="checkbox"/> Radiologist <input type="checkbox"/> Radiation Oncologist <input type="checkbox"/> Reconstructive Surgeon <input type="checkbox"/> Research Nurse <input type="checkbox"/> Surgical Oncologist/ General Surgeon <input type="checkbox"/> Other Physician </p> </td> <td style="vertical-align: top;"> <p>Basic Research</p> <p> <input type="checkbox"/> Basic Research Trainee (grad student/lab-based post-doc) <input type="checkbox"/> Epidemiologist <input type="checkbox"/> Laboratory Scientist <input type="checkbox"/> Research Assistant <input type="checkbox"/> Statistician </p> </td> <td style="vertical-align: top;"> <p>Industry</p> <p> <input type="checkbox"/> Education <input type="checkbox"/> Medical Science Liaison <input type="checkbox"/> Marketing/Sales <input type="checkbox"/> Research <input type="checkbox"/> Other (Please Indicate) _____ </p> </td> <td style="vertical-align: top;"> <p>Other Profession</p> <p> <input type="checkbox"/> Administrator <input type="checkbox"/> Medical Writer <input type="checkbox"/> Other PR <input type="checkbox"/> Patient Advocate <input type="checkbox"/> Other Occupation </p> </td> </tr> </table>					<p>Practice/Clinical Research</p> <p> <input type="checkbox"/> Trainee (Clinical Fellow) <input type="checkbox"/> Data Manager <input type="checkbox"/> Gynecologic Oncologist <input type="checkbox"/> Medical Oncologist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Oncology Nurse <input type="checkbox"/> Other Nurse <input type="checkbox"/> Pathologist </p>	<p> <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Physician Scientist <input type="checkbox"/> Radiologist <input type="checkbox"/> Radiation Oncologist <input type="checkbox"/> Reconstructive Surgeon <input type="checkbox"/> Research Nurse <input type="checkbox"/> Surgical Oncologist/ General Surgeon <input type="checkbox"/> Other Physician </p>	<p>Basic Research</p> <p> <input type="checkbox"/> Basic Research Trainee (grad student/lab-based post-doc) <input type="checkbox"/> Epidemiologist <input type="checkbox"/> Laboratory Scientist <input type="checkbox"/> Research Assistant <input type="checkbox"/> Statistician </p>	<p>Industry</p> <p> <input type="checkbox"/> Education <input type="checkbox"/> Medical Science Liaison <input type="checkbox"/> Marketing/Sales <input type="checkbox"/> Research <input type="checkbox"/> Other (Please Indicate) _____ </p>	<p>Other Profession</p> <p> <input type="checkbox"/> Administrator <input type="checkbox"/> Medical Writer <input type="checkbox"/> Other PR <input type="checkbox"/> Patient Advocate <input type="checkbox"/> Other Occupation </p>
<p>Practice/Clinical Research</p> <p> <input type="checkbox"/> Trainee (Clinical Fellow) <input type="checkbox"/> Data Manager <input type="checkbox"/> Gynecologic Oncologist <input type="checkbox"/> Medical Oncologist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Oncology Nurse <input type="checkbox"/> Other Nurse <input type="checkbox"/> Pathologist </p>	<p> <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Physician Scientist <input type="checkbox"/> Radiologist <input type="checkbox"/> Radiation Oncologist <input type="checkbox"/> Reconstructive Surgeon <input type="checkbox"/> Research Nurse <input type="checkbox"/> Surgical Oncologist/ General Surgeon <input type="checkbox"/> Other Physician </p>	<p>Basic Research</p> <p> <input type="checkbox"/> Basic Research Trainee (grad student/lab-based post-doc) <input type="checkbox"/> Epidemiologist <input type="checkbox"/> Laboratory Scientist <input type="checkbox"/> Research Assistant <input type="checkbox"/> Statistician </p>	<p>Industry</p> <p> <input type="checkbox"/> Education <input type="checkbox"/> Medical Science Liaison <input type="checkbox"/> Marketing/Sales <input type="checkbox"/> Research <input type="checkbox"/> Other (Please Indicate) _____ </p>	<p>Other Profession</p> <p> <input type="checkbox"/> Administrator <input type="checkbox"/> Medical Writer <input type="checkbox"/> Other PR <input type="checkbox"/> Patient Advocate <input type="checkbox"/> Other Occupation </p>					
<p>How long have you been in practice?</p> <p> <input type="checkbox"/> 1-5 years <input type="checkbox"/> 6-20 years <input type="checkbox"/> >20 years </p>									

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SABCS REGISTRATION CATEGORIES

	Virtual Registration Fees
Regular Registration	\$540.00
AACR Member Member ID _____	\$459.00
BCM Faculty & Staff (valid ID required w/registration)	\$267.00
UT Health San Antonio Faculty & Staff (valid ID required w/registration)	\$230.00
Resident or Postdoctoral Fellow (valid ID or letter of appointment)	\$135.00
Student (valid ID required w/registration)	\$56.00
Patient Advocate*	\$0.00

For advocate program information and possible financial assistance, contact Alamo Breast Cancer Foundation PO Box 780067, San Antonio TX 78278 or sandistanford@alamobreastcancer.org

*The patient advocate registration category is reserved exclusively for patient advocates and is not intended for medical professionals. Individuals interested in registering under this category either work or volunteer for national not-for-profit patient advocacy organizations that demonstrate a charitable mission, engage in patient advocacy activities, provide support for people with cancer, have a nonprofessional membership, do not offer CME or scientific programs for professionals. Individuals registered under this category are not eligible to receive continuing education credit for their attendance.

SABCS IS UNABLE TO REFUND OVERPAYMENT OF VIRTUAL SYMPOSIUM REGISTRATION FEES.

METHOD OF PAYMENT Payments must be US currency. Checks must be drawn on US bank.

No Purchase Orders

Check Payable to UTHSCSA #156326

Wire your bank to ours. Add \$32 for wire transfer fee. Wire transfer instructions will be emailed.

AMEX MasterCard Visa Discover

Credit Card Number _____

Cardholder Name _____

Exp Date (MM/YYYY) _____ Card Code Verification (CCV) _____

Address _____ Zip/Post _____ Country _____

Signature _____

RETURN BY

Mail:

San Antonio Breast Cancer Symposium
7979 Wurzbach Road, MC 8224
San Antonio, Texas 78229

Email: sabcs@uthscsa.edu

Fax: 210-450-1560

I authorize SABCS 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 the SABCS and it is SABCS' sole discretion whether to make any adjustments to the payment.

Cancellation Policy. Cancellations must be received in writing prior to December 1, 2020 and are subject to the following processing fees: \$75.00 Regular Registration, AACR Member, UT Health San Antonio Faculty & Staff and BCM Faculty & Staff, \$20.00 Resident or Postdoctoral Fellow, \$20.00 Patient Advocate. Refunds will not be granted after December 1, 2020 nor will they be given for no-shows. Please email cancellations to sabcs@uthscsa.edu.

Substitution Policy. Substitution of registration (same type) is permitted prior to December 1, 2020. Only one substitution is permitted per original registrant with written consent. Written consent from the original registrant or by the person who paid for the registration is required. The individual submitting the substitution request is responsible for all financial obligations associated with that substitution as well as updating any contact/demographic information. Please email substitution requests to sabcs@uthscsa.edu.

If you require special assistance to fully participate in SABCS, please email the Symposium office at sabcs@uthscsa.edu.

For registration inquiries or requests, contact the Symposium office at 210-450-1550 or sabcs@uthscsa.edu