

**5th Annual Mayo Clinic International Spine Surgery Symposium**  
**January 31 – February 4, 2010 • Mauna Lani Bay Hotel • Big Island, Kohala Coast, Hawaii**

Please complete registration online at <http://www.mayo.edu/cme>

**Or: Mail or FAX form with payment to:**

Mayo School of Continuous Professional Development  
 Plummer 2-60  
 200 First Street SW  
 Rochester, MN 55905

Phone 800-323-2688 or 507-284-2509  
 FAX 507-284-0532  
 E-mail [cme@mayo.edu](mailto:cme@mayo.edu)  
 Web site [www.mayo.edu/cme/spine](http://www.mayo.edu/cme/spine)

(Please print or type all information. You may duplicate this form for multiple registrations.)

**Contact Information**

Name of Registrant - first name, middle name or initial, and last name		Degree - select all that apply <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PhD <input type="checkbox"/> PA <input type="checkbox"/> Other - specify:	
Name of Institution		Medical Specialty	
Work/Business Address - street address		Work Phone - include all country and city/area codes as needed along with complete phone number	
City	State or Province	ZIP or Postal Code	Country
Home Address - street address		Home Phone - include all country and city/area codes as needed along with complete phone number	
City	State or Province	ZIP or Postal Code	Country
E-mail Address	FAX - include all country and city/area codes as needed along with complete phone number		FAX Location - select one <input type="checkbox"/> Work/Business <input type="checkbox"/> Home

<b>SPECIAL NEEDS</b>	If you have special assistance needs or dietary restrictions, describe here:
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**Registration Fee**

Registration	Before 11/30/09	After 11/30/09	\$ _____
Physicians & Scientists	\$1,095	\$1,295	\$ _____
Residents & Fellows, Physician Assistants, Nurse Practitioners, Others	\$895	\$1,095	\$ _____
<b>Optional MOC Self-Assessment Modules</b>			
<input type="checkbox"/> I will attend Neurosurgery MOC <input type="checkbox"/> I will attend Orthopedic MOC			
<b>Reception:</b> <input type="checkbox"/> I will attend <input type="checkbox"/> I will not attend			Complimentary
<b>Guest Breakfast Fee:</b>	\$195 x _____ (no. of guests) =		\$ _____
	\$90 x _____ (no. of children 18 & under) =		\$ _____
<b>Guest Reception Fee:</b>	\$75 x _____ (no. of guests) =		\$ _____
	\$45 x _____ (no. of children 18 & under) =		\$ _____

**Payment Information** (All wire transfers will be assessed a \$25 USD fee.)

<input type="checkbox"/> Check is enclosed in the amount shown at right - make checks payable to Mayo Clinic		Payment Total
Credit Card - select one <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa	Account Number      Exp Date - mm/yy	
Name of Cardholder - as it appears on the card		Signature of Cardholder - required <b>X</b>