



CONFERENCE REGISTRATION FORM

Name _____
Last Name First Name Middle Initial Credentials

Mailing Address _____

City _____ State _____ ZIP _____

Institution _____ Email* _____

Office Phone () _____ Alternate Phone () _____ Fax () _____

**E-mail required for confirmation. If you have not received a confirmation email within 14 days of submitting this form, contact pcics@societyhq.com.*

What is your primary medical specialty? Cardiology Critical Care Cardiac Surgery Anesthesia Neonatology
 Cardiac Nurse Cardiac Nurse Practitioner Other **Have you attended a PCICS conference before?** Yes, I attended in _____. No

Do you have any dietary restrictions? If so, please list _____

CONFERENCE REGISTRATION FEES

Your registration fee covers all refreshment breaks, welcome reception, breakfast, access to the mobile meeting guide and program at a glance.

	Through October 10, 2016	Through November 7, 2016	After November 7, 2016
<input type="checkbox"/> MEMBER Physician	\$875	\$925	\$975
<input type="checkbox"/> NON-MEMBER Physician	\$925	\$975	\$1,025
<input type="checkbox"/> MEMBER Nurse/Allied Health	\$575	\$625	\$675
<input type="checkbox"/> NON-MEMBER Nurse/Allied Health	\$625	\$675	\$725
<input type="checkbox"/> MEMBER Resident or Fellow	\$575	\$625	\$675
<input type="checkbox"/> NON-MEMBER Resident or Fellow	\$575	\$625	\$675
<input type="checkbox"/> Nurse Faculty	\$285	\$285	\$285
<input type="checkbox"/> Physician Faculty	\$875	\$875	\$875
<input type="checkbox"/> Resident or <input type="checkbox"/> Fellow Faculty	\$575	\$575	\$575
Postgraduate Sessions - Thursday, December 8 <input type="checkbox"/> Physician Course <input type="checkbox"/> Nursing Course	\$50	\$75	\$100
<input type="checkbox"/> EP Hands-on Session - Saturday, December 10	N/C	N/C	N/C
Choose your preferences for the sessions below. ▼ There is no additional charge for breakout sessions.	TOTAL AMOUNT DUE		\$ _____

Friday, December 9 Concurrent Breakout Sessions	Saturday, December 10 Concurrent Breakout Sessions
1:00 pm - 3:00 pm (included in conference registration) <input type="checkbox"/> Multidisciplinary Session 1 – Those Other Pesky Organs <input type="checkbox"/> Multidisciplinary Session 2 – Nutrition <input type="checkbox"/> Multidisciplinary Session 3 – Prematurity and ACHD 3:30 pm - 5:30 pm (included in conference registration) <input type="checkbox"/> Physician Session 4 – ADHF in Children: State of the Art <input type="checkbox"/> Physician Session 5 – Neuro Critical Care <input type="checkbox"/> Multidisciplinary Session 6 – HLHS: Foundations of Care from Fetus to Fontan	PM 1:00 pm - 3:00 pm (included in conference registration) <input type="checkbox"/> Multidisciplinary Session 1 – Pro/Con Debate <input type="checkbox"/> Physician Session 1 - Clinical Decision Making: Pitfalls, Practices and Tools <input type="checkbox"/> Physician Session 2 – Abstract Challenging Cases

PAYMENT INFORMATION: Check (made payable to PCICS) Credit Card: VISA MasterCard Discover AMEX

Card No. _____ Exp. Date _____ CVV Code _____

(CVV Code is the 3-digit number in signature box on the back of VISA/MC/Discover or 4-digit number on front of AMEX card above the card number)

Card Billing Address _____ Card Billing ZIP _____

Signature _____ Printed Name on Card _____

Americans with Disabilities Act: PCICS has fully complied with the legal requirements of the ADA and the rules and regulations thereof. If any participant in this educational activity is in need of accessible accommodations, please contact PCICS in advance at pcics@societyhq.com.

Cancellation Policy: Refund requests should be submitted in writing to pcics@societyhq.com by November 1, 2016. A \$50 processing fee will be deducted from all refunds. We regret that refunds cannot be honored for requests received after November 1, 2016. Substitutions are not allowed.

Email, mail or fax to: PCICS • 2209 Dickens Road, Richmond, VA 23230-2005 • pcics@societyhq.com • Phone (804) 565-6398 • Fax (804) 282-0090