



9th Annual Rachmiel Levine Diabetes and Obesity Symposium

ADVANCES IN DIABETES BIOLOGY, IMMUNOLOGY AND CELL THERAPY

All requested information must be provided to process registration.

First Name _____

Last Name _____ Degree _____

Institution/Organization _____

Address _____

City _____ State _____ Postal Code _____

Country _____ If outside the U.S., include country/city code _____

Phone _____ Fax _____

Email _____

1. I CONSIDER MYSELF PRIMARILY (check one)

- Clinician Educator Scientist Industry

2. CHOOSE THE SPECIALTY THAT BEST DESCRIBES YOUR AREA OF PRACTICE (check one)

- Cell Biology Diabetology Endocrinology
 Immunology Islet Biology Medicine
 Nursing Transplant Science Other _____

3. PLACE OF WORK (check one)

- Academic Private Practice Hospital Industry

4. SPECIAL NEEDS

Please indicate special needs on a separate sheet and mail to: Levine Symposium, c/o Karen Ramos 1500 East Duarte Road, Duarte, CA, 91010 or email: levinesymposium@coh.org.

In case of emergency during the meeting, please contact:

Name _____

Day Phone _____ Evening Phone _____

REFUND POLICY

All refund requests must be submitted in writing and postmarked no later than **January 31, 2009**. Refund requests postmarked on or before January 31 will receive a registration refund LESS a \$100 processing fee. Refund requests postmarked after January 31, 2009 will not be honored. All refunds will be processed 30 days after the meeting concludes. In the event of unforeseeable circumstances that lead to the cancellation by the conference organizers of the above-mentioned conference, all registration fees would be fully refunded.

5. REGISTRATION FEES

(Please circle the appropriate fee category)

	On/Before 12/31/08	On/Before 03/08/09	After 03/09/09
Four Days			
Physician/Scientist/Industry	\$450.00	\$475.00	\$500.00
Fellow/Resident/Nurse/ Research Associate/Student (Must provide proof of status with registration)	\$275.00	\$300.00	\$325.00

Single Day	\$200.00	\$225.00	\$250.00
Please indicate which day(s) you will be attending:			
<input type="checkbox"/> 03/18/09	<input type="checkbox"/> 03/19/09	<input type="checkbox"/> 03/20/09	<input type="checkbox"/> 03/21/09

Total Amount Enclosed:	\$ _____
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6. MEETING EVENTS (Please indicate which event you will be attending)

- Dinner Lecture/Presentation of Scientific Achievement Awards - \$0
Wednesday, 03/18/09
 Poster Session - \$0
Thursday, 03/19/09

7. SPECIAL MEETING/CONVENTION THEME PARK TICKETS

are available at a discounted rate to Levine Symposium guests by visiting the Conference Web Site

REGISTRATION

BY MAIL

Checks/money orders for registration fees must be made payable to **City of Hope - Levine Symposium**. Mail your completed registration form with check or money order to: Levine Symposium, Attn: Karen Ramos, 1500 East Duarte Road, Duarte, CA, 91010

BY FAX

Send your completed form with credit card payment to (626) 301-8489.

ONLINE

www.levinesymposium.com

CREDIT CARD INFORMATION

- MasterCard Visa American Express Discover

Card Number _____ Expiration Date (Month/Year) _____

Cardholder's Name (as it appears on card) _____

Address (as it appears on card) _____

City _____ State _____ Postal Code _____

Country _____

Signature _____ Date _____