29TH ANNUAL **AVIDsymposium Registration**

Hilton New York - Midtown
1335 Avenue of the Americas
New York, New York 10019

FRIDAY, NOVEMBER 16, 2017 - SATURDAY, NOVEMBER 17, 2018

First Name:_____ Last Name (Surname, Family Name): _____Degree:_____

☐ Physician ☐ Non-Physician Cleveland Clinic Employee? ☐ Yes ☐ No Specialty: _____

Affiliation: _____

Address Type: ☐ Home ☐ Other Address: _____

City:_____State/Province: _____ Zip/Postal Code: _____ Country: _____

E-mail: _____ (A valid registrant's e-mail address is required for confirmation and CME Certificate.)

Alternate E-mail: _____(contact person)

Phone: _____ Fax: _____

Full Registration	**Tuition***
☐ Technologists ☐ Sonographers ☐ Residents ☐ Nurses	$500
☐ Medical & Ultrasound Students (*Letter of verification from Dean must be faxed to (888) 418-7043.)*	$175
☐ Physicians	$695
☐ Physicians Combination Rate - AVIDsymposium and VEITHsymposium	$1899
☐ Nurse Practitioners ☐ Physician Assistants (non-physician,clinician)	$595
☐ All Others	$650

***Cancellation Policy: There is a $95 cancellation fee if canceled in writing by October 12, 2018 . No refunds will be made thereafter.**

Payment Method

☐ **Check** Please make checks payable to the Cleveland Clinic Educational Foundation and mail to:
The Cleveland Clinic Educational Foundation
Attn: 02010961
P.O. Box 931653
Cleveland, OH 44193-1082

If paying by courier such as Federal Express, UPS or DHL, send check to:
The Cleveland Clinic Educational Foundation
Attn: Lockbox 931653
4100 West 150th Street
Cleveland, OH 44135

Checks must be received by October 31, 2018. **Please include a copy of this registration form with your payment.**

☐ **Credit Card**

Name on Card: _____ ☐ Amex ☐ MC ☐ VISA

Credit Card Number:_____ Verification Code (3-or 4-digit security code located on your card): _____

Expiration Date: _____ Signature: _____