

ATTENDEE FORM

ESRD Network Annual Meeting, October 14, 2010 - Sturbridge Host Hotel

- You are not officially listed as an attendee until your personal or facility check has been received at the Network office. No written confirmation will be sent, but you can call the Network office for verification. If your facility is issuing a group check, copies of ALL the attendee forms must be enclosed with the check. All deadlines apply - NO EXCEPTIONS.
- **CANCELLATION POLICY:** Must be cancelled prior to October 1st without penalty. After that time the meeting fee will be non-refundable.
- By attending this meeting, you are also granting permission for the Network of New England to take photographic images during the course of the day to be used and published (through print & electronic media) for the purposes of public education and program description (*Note: Images will not be altered in any way to misrepresent the context in which they were taken*).
- Please be prepared to provide your professional license/registration number(s) on the day of the meeting for continuing education/attendance certificates.

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- | | |
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| <input type="checkbox"/> "Early-Bird" application (<i>postmarked by September 17th</i>) | \$40 |
| <input type="checkbox"/> ANY application (<i>postmarked after September 17th</i>) | \$55 |

(Note: After October 1st, please call first to check for space availability)

Your payment covers the administrated costs associated with applying for Continuing Educational Credits, continental breakfast, luncheon, & refreshment breaks. **Due to catering commitments, no refunds will be given after October 1st.**

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| <input type="checkbox"/> Patients, PAC, Current Network of New England Board of Directors, & Medical Review Board Members (<i>you must submit an attendee form by September 17th</i>) | Complimentary |
| <input type="checkbox"/> Principal Authors/Posters, please subtract \$25.00 from your application | |

*Please make checks payable to:
(No credit cards please.)*

ESRD Network of New England, Inc.
30 Hazel Terrace - Suite 14
Woodbridge, CT 06525

NAME & CREDENTIALS: _____

(As you would like it to appear on your nametag, print clearly)

HOME ADDRESS (Mandatory): _____

CITY, STATE, ZIP: _____

DAYTIME PHONE: _____ DAYTIME FAX: _____

DAYTIME EMAIL: _____

FACILITY (Mandatory): _____ Medicare Provider #(Mandatory): _____

TITLE/POSITION IN FACILITY: _____ ANNA Member Yes No

For confirmation or questions, contact Terri Ross - tross@nwl.esrd.net or
Cynthia Lambert, RN - clambert@nwl.esrd.net PHONE: 203-387-9332 FAX: 203-389-9902