

Indiana Podiatric Medical Association

ADVANCE REGISTRATION FORM

2011 FALL CONVENTION

NAME : _____

ADDRESS: _____

CITY, STATE & ZIP CODE : _____

OFFICE TELEPHONE NUMBER: _____ FAX: _____ E-mail : _____

OFFICE STAFF NAMES : _____

I give the Indiana Podiatric Medical Association permission to ____ fax me and/or ____ email me at the address/fax number above.

Doctors and Assistants Registration Fee includes Educational Sessions, Continental Breakfast and Breaks each day plus Friday Lunch and Saturday Recognition Lunch.

(PLEASE CHECK CATEGORY AND AMOUNT FOR WHICH YOU ARE REGISTERING)

<u>REGISTRATION FEES:</u>	<u>BEFORE 9/05/11</u>	<u>AFTER 9/05/11</u>
IPMA MEMBER	\$425	\$450
APMA MEMBER	475	500
NON-MEMBER	1000	1050
*LIFE MEMBERS	75	100
*RESIDENTS & STUDENTS	00	25

ASSISTANTS' GENERAL PROGRAM:

IPA OR ASPMA MEMBER	200	225
NON-IPA OR NON-ASPMA MEMBER	225	250

ASSISTANTS, REVIEW COURSE FOR THE ASPMA CLINICAL EXAMINATION: ASPMA MEMBERS ONLY (The Registration Fee includes Educational Sessions, Continental Breakfast and Breaks each day plus Friday Lunch and Saturday Recognition Lunch)

Clinical Course	215	n/a
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IN ADDITION, YOU MUST COMPLETE THE ATTACHED REGISTRATION FORM IF YOU ARE REGISTERING FOR THE EXAM

*(Life Members and Resident categories do not include meal charges or social function charges. This fee is for scientific sessions only.)

INDIVIDUAL FOOD FUNCTION PRICES:

Pay only if you do not plan to attend any other functions. These are included in the registration fee listed above except for Life Members and Residents.

<u>REGISTRATION FEES:</u>	<u>BEFORE 9/05/11</u>	<u>AFTER 9/05/11</u>
FRIDAY LUNCH	40	50
SATURDAY RECOGNITION LUNCH	55	65
TOTAL AMOUNT ENCLOSED \$ _____		

NAMES OF ASSISTANTS REGISTERING FOR PMAC CLINICAL REVIEW COURSE AND EXAMINATION:

PAYMENT METHOD: Payment type (check one). Registration will not be processed unless accompanied by full payment.

Check enclosed: ____ MasterCard: ____ Visa: ____ Discover: ____

Credit Card Number (please print clearly) plus Three Digit Card Identification Data (on back of card) & Expiration Date

Name on Card (please print) Authorized Signature

Return to: Indiana Podiatric Medical Association
101 W. Ohio St. Suite 780
Indianapolis IN 46204
Fax: 317-222-3849
e-mail: inpma@indianapodiatric.org
Telephone: 317-222-3847

ASPMA CLINICAL EXAMINATION REGISTRATION FORM

If you are a current member of ASPMA, you are eligible to take the certification exam. **YOU MUST ENCLOSE A COPY OF YOUR CURRENT MEMBERSHIP CARD WITH THIS EXAM REGISTRATION FORM.**

Name _____

Employer _____

Address _____

City, State, ZIP _____

Phone _____ FAX _____ E-mail _____

Cell Phone _____

Requested Exam Site Indianapolis IN

Exam Fee - \$50 (Prior to September 7, 2011)

Late Fee - \$25 (Prior to September 12, 2011)

Have you enclosed the following? (check-off list)

Completed Exam Registration Form (yes) _____

A check in the amount of \$50 (yes) _____

A late fee of \$25 (yes) _____

A copy of your current ASPMA

Membership Card (yes) _____

Mail completed form, check and copy of ASPMA membership card to:

Sue Hasenour, PMAC

4472 S Cross Street

Saint Anthony, IN 47575

Phone: (812) 326-2046 FAX: (812) 326-2659 E-mail: suehpmac@gmail.com

****A \$25 Fee will be charged on all Returned Checks****

PLEASE NOTE: Upon receipt of your Exam Registration Form, Fee, and Proof of Eligibility, you will be sent a "Confirmation" that MUST be presented to the Exam Proctor on the day of the exam. You must also register for the IPMA Convention at the price listed on the registration form.

***VISA, Mastercard, American Express or Discover – If you wish to pay by credit card. Please circle which card you are using.**

Card # _____ Exp Date ___/___

Name on Card _____ Billing Zipcode _____

Signature Required _____

CVV # (3 digit number on back of card) _____