

END EPILEPSY® SUMMIT
Epilepsy Foundation of Greater Los Angeles

REGISTRATION FORM

CME Conference for Physicians + Other Healthcare Professionals | APRIL 28, 2017

Contact Information

Name	Title + Affiliation		
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Email	Phone Number	<input type="checkbox"/> Mobile	<input type="checkbox"/> Home <input type="checkbox"/> Work
Mailing Address	City	State	Zip
<input type="checkbox"/> Neurologist	<input type="checkbox"/> Epileptologist	<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Dietitian	<input type="checkbox"/> Adult w/ Epilepsy	<input type="checkbox"/> Other:	<input type="checkbox"/> Resident/Fellow <input type="checkbox"/> Nurse Practitioner

Yes, I will be attending the Physicians Reception following the conference.

Payment Information

Please enter your Registration Fee below and/or a donation, and calculate the Total Amount Due. The fee helps to cover refreshments, lunch, and conference materials. Onsite registration may increase to \$100/per person.

Summit Fee	\$50/per person (until 3/31/17) \$75/per person (4/1/17-4/28/17)	\$
Reception	\$25/per person (Reception is only for MDs [with a few exceptions]. Questions? Ask Rebekkah)	\$
Other Donation	Tax-deductible donations welcome to help support conference scholarships	\$
Total Being Paid	The total amount should match the amount on your check or credit card	\$

Consider me for a partial scholarship. Share why below. We will confirm acceptance by April 15, 2017.

Payment Method

- Check enclosed (# _____) Make checks payable to: **EpilepsyFoundationGLA**
 Please bill my credit card: Visa MasterCard Discover American Express

Credit Card #	CVV#	Exp. Date:	/
Name on Card	Signature		
Billing Address			

Return Completed Form

Email: Summit@EndEpilepsy.org | Tel: (310) 670-2870 | Fax (310) 670-6124
Mail: Epilepsy Foundation GLA, 5777 W. Century Boulevard, #820, Los Angeles, CA 90045



STAFF USE ONLY

Rec'd Date: _____
Staff Initials: _____
Promo Code: _____
(if applicable)