



REGISTRATION FORM
SYRIAN AMERICAN MEDICAL SOCIETY
 Damascus July 4th - 7th, 2010

Last Name: _____ Middle Initial: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Fax: _____ Email: (required) _____

Specialty: _____ Year of Graduation: _____

Present work: (please circle one) Private Practice Academic Resident Fellow Student

Academic Title if any (Please include your title, affiliation, city & state) _____

Deadline for Registration: June 1st, 2010

	Registration fees before March 15 th	Registration fees after March 15 th	Registration fees On site	Total
National Membership Dues	\$ 150	\$ 150	\$ 150	\$ _____
Local Chapter Dues <i>(Please specify chapter or group if you belong to one)</i> <input type="checkbox"/> Illiana <input type="checkbox"/> Michigan <input type="checkbox"/> Northeast <input type="checkbox"/> Ohio <input type="checkbox"/> SAMS New Group	\$ 50	\$ 50	\$ 50	\$ _____
Members	\$ 425	\$ 475	\$525	\$ _____
Non Members	\$ 675	\$ 725	\$ 775	\$ _____
US Medical Residents/Fellows	\$ 100	\$ 125	\$ 125	\$ _____
Syrian Physicians	5000 Sy Pds.	5000 Sy Pds.	5000 Sy Pds.	\$ _____
Syrian Medical Residents/Students	Free	Free	Free	\$ _____
Additional Gala Dinner Tickets	\$100	\$100	\$100	\$ _____
Donation to SAMS Foundation <i>(Proceedings will go to local Syrian Charities)</i> NGO				\$ _____
Grand Total				\$ _____



PAYMENT METHOD

Credit Card Payment
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
Credit Card Number: _____ - _____ - _____ - _____
Credit Card Exp. Date: _____
Signature: X _____

Make Checks Payable to SAMS

- Please accept my check
Amount : \$ _____ Check #: _____
- Please bill my credit card
Amount: \$ _____

Questions?
 Please contact SAMS
 (866) 809-9039
samsconference@gmail.com

Payment due by Check or
Credit Card

Mail Payment To:
 SAMS
 PO Box 1015
 Canfield, OH. 44406

By Fax:
 (330) 286-0325