REGISTRATION FORM
SYRIAN AMERICAN MEDICAL SOCIETY
Disney Coronado Spring Resort
Orlando, FL.
Feb 17-20, 2012

Please complete your information below:

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) _____

_____

Membership Dues ***(Required for everyone including all chapters and groups)***
Otherwise register for conference as non-member

National Membership Dues
Physicians $150, Students, Residents & Fellows complimentary $ _____

Local Chapter & Group Dues: (from list) $ _____
Please circle chapter or group you belong to

A. Total Membership Dues: $ _____

(Please circle chapter or group you belong to)

Local Chapter Dues

Michigan	$50
Midwest	$50
Northeast	$50
Ohio	$50
WV Chapter	$50

SAMS Group Dues

SAMS Thoracic Group	
Practicing physicians	$100
Residents & Fellows	$50

Deadline for Registration: Jan 31st, 2012 – No gala dinner tickets available for sale onsite

Conference Registration	**Registration fees before Jan 30st**	**Registration fees On site**	**Total**
Physician Members *(including 1 gala dinner ticket)* ***no tickets will be available on-site***	$ 375	$400	$ _____
Non Members - Physicians *(including 1 gala dinner ticket)*	$ 550	$ 650	$ _____
Fellows/ Residents	$ 175	$225	$ _____
Additional Gala Dinner Ticket - Adults *(specify quantity __)*	$100	$100	$ _____
Gala Dinner Ticket – Children 12yrs and under *(specify quantity __)*	$40	$40	$ _____
Donation to SAMS Foundation			$ _____
B. Registration Total			**$ _____**

TOTAL PAYMENT ENCLOSED (A+B) $_____

Payment due by Check or Credit Card

Credit Card Payment
□ Visa □ MasterCard
Credit Card Number: _____ - _____ - _____ - _____ **Exp. Date:** _____
Signature: _____

□ Please accept my check
Amount : $ _____
Check #: _____

□ Please bill my credit card
Amount: $ _____

Make Checks Payable to SAMS
Mail Payment To:
SAMS
PO Box 1015
Canfield, OH. 44406
By Fax: (330) 319-8989