

**1<sup>st</sup> Annual Pain Day Symposium**  
**JANUARY 20<sup>th</sup>, 2018**  
**Official Registration Form**

PERSONAL INFORMATION					
NAME (Prefix, First, Last)					
PROFESSION:			EMPLOYER:		
CONTACT NUMBERS:	HOME:		CELL:		WORK:
EMAIL ADDRESS: (PLEASE PRINT)					

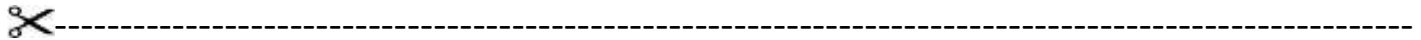
REGISTRATION INFORMATION		
Please tick (✓) the appropriate box	EARLY REGISTRATION	ONSITE
Physicians	<input type="checkbox"/> \$225.00	<input type="checkbox"/> \$300.00
Others: Interns, Nurses, Allied Health	<input type="checkbox"/> \$180.00	<input type="checkbox"/> \$200.00
Medical Students	<input type="checkbox"/> \$80.00	<input type="checkbox"/> \$100.00
<ul style="list-style-type: none"> <li>Early registration ends Sunday December 31<sup>st</sup>, 2017</li> <li>Limited number of Medical Students allowed at this rate on a first registered basis</li> <li>Payment is required to confirm registration</li> <li>Please make ALL cheques, bank drafts or money orders payable to: <u>The University of the West Indies</u></li> </ul>		

Please indicate if you prefer Vegetarian meals?      Yes       No

For Official Use Only:

Amount Paid:    Cash: \$ \_\_\_\_\_    Cheque: \$ \_\_\_\_\_    Credit Card: \$ \_\_\_\_\_

Date Paid: \_\_\_\_\_    Paid By: \_\_\_\_\_    Received By: \_\_\_\_\_



**1<sup>st</sup> Annual Pain Day Symposium Credit Card Payment Information**

FINANCIAL INFORMATION					
CARDHOLDER NAME:			CARDHOLDER TEL #:		
CREDIT CARD TYPE:	VISA <input type="checkbox"/>	MASTER <input type="checkbox"/>	CARD #:	EXP. DATE: ___ / ___	
3 DIGIT CODE#			CARDHOLDER EMAIL:		
BANK ISSUING CARD:			AMOUNT TO BE CHARGED:	\$ _____	BDS <input type="checkbox"/> USD <input type="checkbox"/>

\_\_\_\_\_  
 Cardholder Signature