

The American Orthopaedic Association
The AOA~Kellogg Leadership Series
Module Five, September 14-16, 2007

To expedite the processing of your registration, you may register online instead of completing this form. If you have Internet access, please visit the AOA Web site to register online. AOA Web site: <http://www.aoassn.org>

Program Transfers:

Program transfer requests to a future session **must be received in writing**. Registrants are permitted **one transfer only** before forfeiting the total tuition fee.

Transfer requests received 61 days or more prior to the first day of the program (July 15 or before) will incur a \$75 transfer fee; 31 to 60 days prior to the first day of the program (July 16 to August 14) will incur a 50% transfer fee. Transfer requests received within 30 days or less prior to the first day of the program (August 15 or after) will forfeit tuition fee.

Please fax your request to 847.318.7339 attention Kellogg Registrar or send an email request to Kellogg@aoassn.org.

Cancellation Policy:

All cancellations and refund requests **must be received in writing**. Cancellations received 61 days or more prior to the first day of the program (July 15 or before) will receive at 50% refund. Cancellations received within 60 days or less of the first day of the program (July 16 or after) will forfeit tuition fee.

**NOTE: This policy applies to all forms of payment. Please fax your request to 847.318.7339 attention Kellogg Registrar or send an email request to Kellogg@aoassn.org.*

Required Acceptance: I acknowledge that I have read and accept the conditions of this policy.

A1. NAME OF PERSON PROCESSING REGISTRATION ON BEHALF OF DELEGATE

(*indicates required information)

*Name _____ *Telephone# _____ *Email _____

A2.. PARTICIPANT INFORMATION

Delegate Information (*indicates required information)

*Salutation: Dr. Mr. Mrs. Ms. Other _____

*First name _____ Middle Initial _____

*Last name _____ Title/Desig. _____

Organization/Institution _____

* Mailing address _____

*City _____ *Province/State _____

*Postal/ZIP code _____ *Country _____

*Telephone# _____ Fax # _____

*E-mail _____

Special Needs

Dietary restrictions: Vegetarian Kosher Food allergy(s) _____

