WORKSHOP REGISTRATION FORM

ADVANCE REGISTRATION DEADLINE: FRIDAY, AUGUST 31, 2018

Please Print Clearly

Registrant Name: ___________________________ Degree(s): ___________________________

Institution: ________________________________
Department: ________________________________
Street Address: ________________________________
City: __________________ State/Province: ___________ Zip/Postal Code: ___________ Country: ___________

Email: ____________________ Phone: ___________

~ INDICATE YOUR REGISTRATION CATEGORY ~

- APS Member* ................................................................. $400
- Retired APS Member* ....................................................... $200
- APS Postdoctoral Member* ........................................... $300
- APS Student Member* ....................................................... $200
- Nonmember ....................................................................... $550
- Nonmember Postdoctoral** ........................................... $350
- Nonmember Student ........................................................ $250

STUDENT ELIGIBILITY:
“I certify that the student registrant is presently enrolled at this university and is working toward a degree in a field related to the topic of this meeting”

Signature of Dept. Head or Advisor

Print Name of Dept. Head or Advisor

*All APS Members must provide their Member ID Number or attach membership certification:

**Nonmember Postdoctoral registrants must fax or email a signed statement from their department head, confirming year of their PhD.

~ SPECIAL DIETARY NEEDS ~

☐ Please check if applicable and list your dietary preference below.

~ REGISTRANT WITH DISABILITY ~

☐ Please check if applicable and list special needs below. This meeting is accessible to all people.

~ PROVIDE PAYMENT INFORMATION ~

☐ Payment by check is enclosed in the amount of $ ________ Check Number: ________

Make check payable to The American Physiological Society. Include this registration form with check.

☐ Please charge my (check credit card type)
  ☐ MasterCard ☐ Visa ☐ American Express: in the amount of $ ________

Credit Card Number: ___________________________ Expiration Date: ___________________________

Name of Cardholder: ___________________________ Signature: ___________________________

Mail/Fax/Email your registration form to: APS Meetings Department, 9650 Rockville Pike, Bethesda, MD 20814-3991, USA; Fax: 301-634-7264; or Email: meetings@the-aps.org. Questions: 301-634-7364.