



International College of Angiology
 Member, Council for International Organizations of Medical Sciences (CIOMS)
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ICA REGISTRATION FORM

58th Annual World Congress ICA 2016
Hotel Pyramida • Prague, Czech Republic
2 – 4 June 2016

Registrant	(Please Print) MD/MBBS/RN, RVT, PA (Family Name) (First Name) (MI)
Accompanying Person(s)	Dr./Prof./Mr./Mrs./Ms. (Family Name) (First Name) (MI)
	_____ (Family Name) (First Name) (MI)
	_____ (Family Name) (First Name) (MI)
Registrant Mailing Address <i>Please check one</i> <input type="checkbox"/> Institution <input type="checkbox"/> Private Clinic <input type="checkbox"/> Home	Institution/Clinic/Home _____ Street _____ City _____ State ____ Country _____ Zip/Postal Code _____ Tel. No. () _____ FAX No. () _____ E-MAIL: _____ Specialty: _____

REGISTRATION FEES: ICA Registration is personal and **non-transferable**. Your fee must accompany this registration form. In order to maintain accurate meal counts and seating for our Congress **please indicate your days of attendance.**

	EARLY REGISTRATION BEFORE 15 MARCH 2016	REGISTRATION MARCH 15, 2016 – 1 MAY 2016	REGISTRATION AFTER 1 MAY 2016
<input type="checkbox"/> ICA Fellows, Associate Fellows [†] , Affiliate Fellows and Members	(USD) \$400 (Entire Congress)	(USD) \$475 (Entire Congress)	(USD) \$550 (Entire Congress)
PLEASE INDICATE DAYS ATTENDING:	<input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday		
<input type="checkbox"/> All Other Non-Fellows	(USD) \$600 (Entire Congress)	(USD) \$675 (Entire Congress)	(USD) \$750 (Entire Congress)
PLEASE INDICATE DAYS ATTENDING:	<input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday		
<input type="checkbox"/> RN's, PA's, RVT's/Allied Medical Services* *(Not Applicable to Oral or Poster Presentations)	(USD) \$200	(USD) \$225	(USD) \$250
PLEASE INDICATE DAYS ATTENDING:	<input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday		
<input type="checkbox"/> Fellows, Residents, Interns & Students**	(USD) \$25	(USD) \$50	(USD) \$75
PLEASE INDICATE DAYS ATTENDING:	<input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday		

[†]Associate Fellows of the ICA, **in good standing**, ARE NOT REQUIRED TO PAY A REGISTRATION FEE as part of their membership benefit. **(Only applies to the first 3 years of membership. Thereafter, the full registration fee applies).** * This fee **IS NOT** applicable to Oral, Video or Poster Presentations. **Requires a letter from the hospital verifying position. Students required to submit a valid student card.

PLEASE FORWARD INFORMATION AND AN APPLICATION FOR FELLOWSHIP

REGISTRATION PAYMENT INFORMATION

Credit Card Type: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>Must be in U.S. funds, drawn on a U.S. bank.</i>
Credit Card Number: _____	<input type="checkbox"/> Check Amount: (USD) \$ _____ Check Nr. _____
Name As It Appears on Card: _____	Expiration Date: _____ / _____ CCV _____ Billing Zip/Postal Code _____ (Required) (Required)
Authorized Signature: _____	

REGISTRATION CANCELLATION POLICY: A written request must be received **no later than 15 April 2016, less a \$50 administrative fee.** There will be a **50% processing fee** for all cancellations received **after 15 April 2016 and before 1 May 2016.** Fees are non-refundable after 1 May 2016.