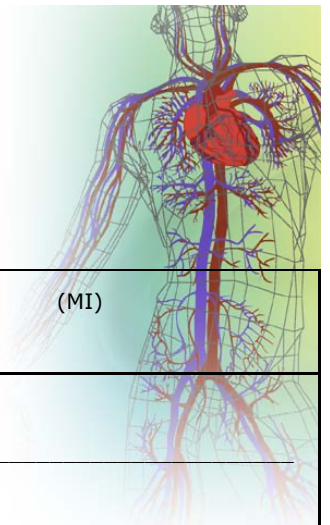


# International College of Angiology

Member, Council for International Organizations of Medical Sciences (CIOMS)  
 EXECUTIVE OFFICE: 161 MORIN DRIVE • JAY, VERMONT 05859 USA  
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63<sup>rd</sup> Annual World Congress • VIRTUAL CONGRESS  
 Northwell Health, Bayshore, New York  
 October 21-23, 2021



## ICA REGISTRATION FORM

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

**REGISTRATION FEES:** ICA Registration is personal and **non-transferable**. **REGISTRATION MUST BE COMPLETED BY 10 OCTOBER IN ORDER TO RECEIVE LOG-IN INSTRUCTIONS**  
 Your fee must accompany this registration form. In order to claim your CME accreditation

<input type="checkbox"/> ICA Fellows, Associate Fellows, Affiliate Fellows and Members	(USD) \$200
<input type="checkbox"/> All Other Non-Fellows <b>WITH</b> a submitted and approved Membership Application	<input type="checkbox"/> <b>NO CHARGE</b> MY APPLICATION FOR MEMBERSHIP IS ATTACHED
<input type="checkbox"/> All Other Non-Fellows <b>WITHOUT</b> a submitted and approved Membership Application	<input type="checkbox"/> (USD) \$300 No Membership Application
<input type="checkbox"/> RN's, PA's, RVT's/Allied Medical Services	<input type="checkbox"/> <b>NO CHARGE</b> MY APPLICATION FOR MEMBERSHIP IS ATTACHED
<input type="checkbox"/> RN's, PA's, RVT's/Allied Medical Services	<input type="checkbox"/> (USD) \$50 No Membership Application
<input type="checkbox"/> Fellows*, Residents*, Interns* & Students**	<b>NO CHARGE</b> (Entire Congress)

\*Requires letter from Department Head or Chair \*\*There is NO Registration Fee for students to attend the ICA Annual World Congress. However, a letter from the University and the submission of a valid student ID card is required.

Credit Card Type:	Must be in U.S. funds, drawn on a U.S. bank.
<input type="checkbox"/> American Express <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> DISCOVER <input type="checkbox"/> PayPal <input type="checkbox"/> BANK	<input type="checkbox"/> Check Amount: (USD) \$ _____ Check Nr. _____

Credit Card Number: _____	Expiration Date: ____/____/____	CCV: _____	Billing Zip/Postal Code: _____
		(Required)	(Required)

Name As It Appears on Card: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

\* This fee IS NOT applicable to Oral or Poster Presentations. \*\* Requires a letter from the hospital/Department Chair or copy of Student ID verifying position.

### REGISTRATION PAYMENT INFORMATION PLEASE FORWARD INFORMATION AND AN APPLICATION FOR FELLOWSHIP

REGISTRATION CANCELLATION POLICY: A written request must be received no later than 10 October 2021, less a \$25 administrative fee. Fees are non-refundable after 10 October 2021.