ON-SITE REGISTRATION FORM
International Society for Heart and Lung Transplantation
39th Annual Meeting and Scientific Sessions
April 3-6, 2019 ● Orlando, Florida

INSTRUCTIONS:

1. **The Annual Meeting registration fee** includes attendance at all Scientific Sessions, Exhibit Hall receptions, and coffee breaks.

2. **The Physician/Surgeon Rate** is available only to individuals who have achieved an MD degree or the equivalent.

3. **The Industry Rate** is available to anyone whose primary employer is a for profit commercial entity, excluding medical centers and healthcare providers. **Individuals who meet this definition MAY NOT register under any other category.**

4. **The Allied Health/Non-Physician Rate** is available to individuals who *have not* achieved an MD or the equivalent (e.g. PhDs, non-MD researchers, nurses, pharmacists, physical therapists, psychologists, social workers, etc.) *and are not* pharmaceutical or device company employees/consultants should select this rate. Non-member allied health registrants must include with their registration forms a letter signed by the chief/dean of their transplant program verifying their employment and allied health status. If you do not have this letter, you must show some type of proof of your status or agree to have a letter faxed or emailed to the ISHLT office no later than April 12, 2019. If this letter is not received by the deadline, you agree to be charged the On-site Full/Physician registration rate.

5. **The Student/Trainee Rate** is available only to individuals who are actively participating in a formal training program (i.e. medical, graduate, and nursing students, residents, fellows, or the equivalent). Non-members choosing this rate must include with your registration form a letter signed by the chief-dean of you program verifying your training status. If you do not have this letter, you must show some type of proof of your status or agree to have a letter faxed or emailed to the ISHLT office no later than April 12, 2019. If this letter is not received by the deadline, you agree to be charged the On-site Full/Physician registration rate.

6. **Guest registration includes** access to the plenary sessions, exhibit hall, wine and cheese receptions. A Guest registration **MUST** be accompanied by a registrant in one of the other categories. (See instructions #7 regarding age restrictions for children.)

7. **Age Restriction**: Children 12 and under are not permitted in sessions and must be accompanied by an adult at all times. Children under the age of 12 are not permitted in the Exhibit Hall at any time.

39th ANNUAL MEETING ON-SITE REGISTRATION FORM

International Society for Heart and Lung Transplantation

38th Annual Meeting and Scientific Sessions, April 3-6, 2019 ● Orlando, Florida

Name:_____
Last First Middle Initial

Credential (MD, RN, etc.) _____ Nickname for badge (if desired) _____

Institution/Organization Name for Inclusion on Badge _____

Preferred Mailing Address. Please indicate if this is a home or business address: [ ] Home [ ] Business

_____

City _____State _____ Post Code _____ Country _____

Telephone (_____) _____ Fax (_____) _____

Email (PRINT CLEARLY):_____

SCIENTIFIC SESSIONS REGISTRATION	US $	TOTAL
☐ Industry Member (See instruction #3) (Blue)	$ 1,370	_____
☐ Industry Non-Member (See instruction #3)(Red)	$ 1,715	_____
☐ Physician/Surgeon Member (industry employees may not register for this category)(Blue)	$ 1,125	_____
☐ Physician/Surgeon Non-Member (industry employees may not register for this category)(Red)	$ 1,470	_____
☐ Allied Health/Non Physician Member (See Instruction #4)(Blue)	$ 760	_____
☐ Allied Health/ Non-Physician Non-Member (See Instruction #4) (Red)	$ 1,105	_____
☐ Student/Trainee Member (See Instruction #5)(Yellow)	$ 690	_____
☐ Student/ Non-Member (See Instruction #5) (Yellow)	$ 860	_____
☐ Guest Registration (see instruction #6) (Pink)	$ 150	_____

Guest Name for Badge: _____

TOTAL PAYMENT DUE $ _____

I agree that if I have registered under a category for which I do not meet the criteria, ISHLT may charge my credit card the appropriate fee for the category for which I do meet the criteria. All credit cards will be charged the US dollar amount shown.

Professional Classification (check one box only):

☐ Anesthesiology
☐ Cardiac Surgery
☐ Cardiology
☐ Cardio-Thoracic/Vascular Surgery
☐ Immunology
☐ Infectious Diseases
☐ Nursing
☐ Pathology
☐ Pediatric Cardiology
☐ Pediatric Pulmonology
☐ Pediatric Transplant Surgery
☐ Perfusion
☐ Pharmacy/Pharmacology
☐ Physician Assistant
☐ Pulmonology
☐ Research
☐ Social Science
☐ Thoracic Surgery
☐ Transplant Coordination
☐ VAD Coordinator
☐ Other: _____
(Must identify)

CREDIT CARD INFORMATION (PLEASE PRINT CLEARLY)

Credit Card: ☐ VISA ☐ Mastercard ☐ American Express

Credit Card # : _____ Expiration Date: _____

Name on Credit Card (Print Clearly): _____

CSC (Credit Card Security Code)_____ Card Holder Billing Zip Code/Postal Code **(Mandatory)**: _____

Card Holder Billing Street Address: **(Mandatory)**_____

Signature: _____