



AIMsymposium Registration

First Name: _____ Last Name (Surname, Family Name): _____ Degree: _____

Physician Non Physician Cleveland Clinic Employee? Yes No Specialty: _____

Affiliation: _____

Address Type: Home Other Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____

E-mail: _____ **(A valid email address is required for confirmation and CME Certificate)**

Phone: _____ Fax: _____

Full Registration

	Tuition
<input type="checkbox"/> Practicing Physicians	\$765
<input type="checkbox"/> Practicing Physicians Combination Rate - AIMsymposium and VEITHsymposium	\$1595
<input type="checkbox"/> Practicing Physicians Combination Rate - AIMsymposium, VEITHsymposium and AVIDsymposium	\$1595
<input type="checkbox"/> US Vascular Surgery Fellows in Training <small>(Tuition provided through an Educational Grant by W.L. Gore & Associates, Inc.)</small> Letter of verification from Chief of Service must be faxed to (845) 496-2242.	Complimentary
<input type="checkbox"/> Non US Fellows <input type="checkbox"/> PhDs <input type="checkbox"/> Residents <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurses <input type="checkbox"/> Technologists	\$325
<input type="checkbox"/> Exhibitors <input type="checkbox"/> Other Allied Health Care Professionals	\$575

Component Meetings*

Wednesday Only - Endovascular Management of Varicose Veins Wednesday Only - Hemodialysis Access Wednesday Only - Neurointervention \$295

(*Complimentary to registrants with full paid registration. Please check the component meeting you wish to attend.)

Payment Method

Check Please make checks payable to the Cleveland Clinic Educational Foundation and mail to:
The Cleveland Clinic Educational Foundation
Attn: 020496
P.O. Box 931653
Cleveland, OH 44193-1082

Name on Card _____ Check Amex MC VISA

Credit Card Number _____ Verification Code (3- or 4- digit security code located on your card) _____

Expiration Date _____ Signature _____