

REGISTRATION INFORMATION: FACE-TO-FACE SEMINARS

REGISTRATION INFORMATION

Dates, speakers and topics subject to change.

Register by Mail

Send your completed registration form and payment to:
Wisconsin Medical Society
Attention: Education Department
PO Box 1109
Madison, WI 53701-1109

Register by Fax

If you are paying the registration fee by credit card, you may fax your completed registration form to the Education Department at 608.283.5424.

Confirmation

If your confirmation does not arrive two working days prior to the program, please contact us to verify your registration.

Refund Policies

If you are unable to attend a face-to-face program for which you are registered, you may send a substitute in your place. If you call the Society at least three days prior to the program, we will refund your registration (minus a \$25 processing fee) or transfer your entire registration fee to another seminar. There is no charge to transfer a registration fee from one person to another provided the request is made at least three business days prior to the activity date. No refunds or transfers will be made unless requested three business days prior to the conference date.

Weather Policy

If the weather is a factor the morning of a face-to-face program, please call us at 608.442.3820 after 6:30 a.m. to verify the program's status. The message will indicate only those programs canceled due to weather. If your program is not listed, it will be held as scheduled. Canceled programs will be rescheduled in your area as soon as possible. You may transfer your registration fee to another program or receive a full refund if the Wisconsin Medical Society cancels the program.

Americans with Disabilities Act

The Wisconsin Medical Society subscribes to the articles of Title III of the Americans with Disabilities Act of 1990. Should you or anyone accompanying you require assistance, please contact the Society at 608.442.3800.

REGISTRATION FORM

Name _____

Clinic/Organization _____

E-mail (required*) _____

Address _____

City _____

State _____ ZIP _____

Telephone _____

Fax _____

Program Code:	Fee:	Program Code:	Fee:
1. _____	\$ _____	4. _____	\$ _____
2. _____	\$ _____	5. _____	\$ _____
3. _____	\$ _____	6. _____	\$ _____

Enclosed is my check for \$ _____
(Please make checks payable to the Wisconsin Medical Society.)

Please charge the following:
 VISA MasterCard Discover

Account Number _____

Expiration Date _____ V-Code _____

Name/Signature of Card Holder _____

Detach this panel and mail with your payment to Education Department, Wisconsin Medical Society, PO Box 1109, Madison, WI 53701 or fax to 608.283.5424.



Wisconsin Medical Society
Your Doctor. Your Health.

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