

Location and General Information

FIRST COME FIRST SERVED

Space is limited for this symposium — please register early.

LOCATION

Hamilton Crowne Plaza

1001 14th Street, NW
(14th and K Streets, NW)
Washington, DC 20005
Hotel Fax: 202-682-9525

Emergency Calls: During the day of this meeting only, March 24th, direct emergency calls to the hotel operator at 202-682-0111.

Hotel Reservations: Group Rate of \$159/night. Cut off date for group rate is Friday, March 3, 2006.

Telephone: 877-227-6963. Make your reservation at the Hamilton Crowne Plaza in Washington, DC. Indicate that you are with ATA/Thyroid and the Environment to receive the group rate.

TRAVEL INFORMATION

The closest airport is Reagan National Airport (DCA). METRO rail is available at the airport to the McPherson Square Metro (2 blocks to hotel) or Farragut North (4 blocks to hotel). The hotel is approximately a 15-minute cab ride from Reagan National Airport. From Dulles Airport the cab ride will be approximately 45 minutes and from BWI approximately 45 minutes.

POLICY ON FACULTY AND DISCLOSURE

It is the policy of the Boston University School of Medicine that the faculty and provider disclose real or apparent conflicts of interest relating to the topics of this educational activity, and also disclose discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). Detailed disclosure will be made in the course handout materials.

AMERICANS WITH DISABILITIES ACT (ADA)

The ATA fully complies with the legal requirements of the ADA and the rules and regulations thereof.

FEES (All Fees are in US Dollars)

Pre-Registration Cut Off Date:

March 21, 2006

Physicians/Scientists/
Government and Public
Health Officials \$275
Residents*/Fellows*/Allied
Health Professionals \$125

*with verification of status

The registration fee includes instructional materials, lunch, and refreshment breaks. Foreign payments must be made by credit card or with a U.S. Dollar World Money Order.

Refund Policy: Refund requests must be submitted in writing. Requests submitted by fax or e-mail before March 15, 2006 will receive a registration refund less a 50% processing fee. No refunds will be made if submitted after March 15, 2006. Refunds will be processed 30 days after the meeting.
Fax number: 703-998-8893
E-mail: admin@thyroid.org

FOR FURTHER INFORMATION

Confirmation of Registration:
678-341-3056

Fax Registration: 678-341-3081

CME Certificates (post-meeting)
617-638-4605 or www.bu.edu/cme

Other Course Information:
703-998-8890
admin@thyroid.org

The ATA national headquarters is at 6066 Leesburg Pike, Suite 550, Falls Church, VA 22041.

The AACE national headquarters is at 1000 Riverside Ave.; Suite 205, Jacksonville, FL 32204.

Meeting Registration Form

REGISTER ONLINE at the secure ATA web site www.thyroid.org
or by mail or fax using this form.

All requested information must be provided to process registration.

First name _____ Last name _____

Nickname for badge _____ MD PhD MD, PhD DO RN Other: _____
Professional degree(s) (please circle one): Title _____

Organization _____

Address _____

City _____ State/Province Zip code + 4 _____

If outside the U.S., country/city _____ Country _____

Phone _____ Fax _____

E-mail address _____

Special Needs. (Dietary, accessibility, etc.) _____

Registration Fees

(Please circle applicable fees.)

	Discounted (received by March 15)	Full Fee (received after March 15)
(D) Physician/Scientist	\$275	\$325
(G) Government/Public Health Official.....	\$275	\$325
(F) Residents*/Fellows*/Allied Health Professional	\$125	\$175
(P) Press.....	\$0	\$0

*With verification of status. Please fax a letter from your program director to 703-998-8893 or by e-mail to admin@thyroid.org.

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|---|---|---|
| <p>1. I require a CME certificate for my attendance at this meeting.
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If pre-registered you can complete the evaluation and CME form and receive your CME certificate as you depart the meeting.</p> | <p>2. I consider myself primarily (please list one): _____
a. Clinician b. Educator
c. Scientist
d. Other: _____</p> <p>3. My work is best described as (please list one): _____
a. Adult endocrinology
b. Basic science
c. Pediatric endocrinology
d. Internal medicine
e. Family Medicine
f. Other: _____</p> | <p>4. My place of work is (please list one): _____
a. Academic
b. Private practice
c. Administration
d. Hospital
e. Government/military
f. Corporate/industry
g. Managed care</p> <p>5. What do you hope to learn by attending this course?

_____</p> |
|---|---|---|

Payment Information:

Check or Money Order (payable to the American Thyroid Association in U.S. dollars drawn on a U.S. bank) Amount enclosed: _____

Credit Card: MasterCard VISA American Express

Card number _____ Expiration date (month/year) _____

Print cardholder's name _____

Signature _____ Date _____

In case of emergency, please contact:

Name _____

Daytime Phone _____ Evening Phone _____

Cell Phone _____

Please keep a copy of this form.