



## **REFUND REQUEST FORM**

15<sup>th</sup> ITC REFUND POLICY: Refund requests must be submitted using this Refund Request Form. Requests submitted by fax or e-mail before August 1, 2015, will receive a refund minus a 10% processing fee. After August 1, 2015, but on or before September 1, 2015, a refund less 50% is available. Cancellation of Trainee and Guest registrations on or before September 1, 2015 are subject to a \$50 U.S. dollars (USD) cancellation processing fee each. Pre-meeting programming and optional ticketed sessions purchased on or before September 1, 2015 are subject to a \$75 USD (each) cancellation processing fee. No refunds for registration or programming will be granted if submitted after 9/1/2015. No refunds will be granted for no-shows. All refunds will be processed 30 days after meeting.

All requested information must be provided to process a refund. All fees are in U.S. dollars.

REGISTRANT (or COMPANY NAME):	 First	Middle	Last
PHONE:	FAX:	E-MAIL ADDRESS:	
ORIGINAL FORM OF PAYMENT: 🗆 M	IC/VISA	☐ Check ☐ Oth	er
ORIGINAL PAYMENT:   Personal	☐ Institution		
NAME of the ORGANIZATION or INDIVIDUAL	who originally paid the registration and	d is due the refund	
ADDRESS 1			
ADDRESS 2			
CITY STATI	E/PROVINCE	ZIP CODE + 4 COUN	ITRY - IF OUTSIDE US, INCLUDE COUNTRY/CITY CODE
PHONE:	FAX:	E-MAIL ADDRESS:	
Reason for cancellation:			
Submitted by:			
Signature	Printed Name		Date
PHONE:	FAX:	E-MAIL ADDRESS:	
Send this form: By email to <a href="mailto:ipaige@thyroid.o">ipaige@thyroid.o</a> By mail to American Thyroid A	<del></del>	ax to 703-998-88 g Pike, Suite 550	393 D Falls Church, VA 22041 USA
Internal use: Form of Refund: ☐MC	□ VISA □ American Express	S □ Check #	Other
Date submitted:	Original payment date:	Origii	nal payment:
Approved:	Amount due:		

