2020 CONFERENCE REGISTRATION

Women Physicians In Christ

2020 WPC Conference

EXHIBITOR REPRESENTATIVE REGISTRATION FORM

September 17-20 / Hyatt Regency Newport Beach, California

Date: _____ **Name:** _____ **Degree:** _____

Badge Name (if different):_____**Specialty:** _____ **Cellphone#**:(_____) _____

Street: _____ **City:** _____ **State:** ____ **Zip:** _____

Email Address: _____**1st time to WPC (WIMD) conference?** _____

☐ **Yes** or ☐ **No** – Do you wish to be on the contact list handed out to attendees at the conference to keep in touch?

☐ **I have special/medical dietary restrictions**_____

☐ **I have special ADA needs:** _____

☐ **My spouse / guest is attending:** **Spouse's/Guest's Name:** _____**Degree**: _____

If spouse would attend Men's Track if offered, provide spouse's email:_____

SELECT YOUR REGISTRATION STATUS:

Registration fees include ALL meals from Friday breakfast – Sunday breakfast except Sat. lunch is on your own

☐ **$645 Graduate**
☐ **$545 Graduates Attending their 1st WPC Conference** ***($100 discount)***
☐ **$645 Allied Health Professional**
☐ **$645 Retired**
☐ **$545 Full-Time Missionary**
☐ **$545 Resident/Fellow**
☐ **$545 Speaker**
☐ **$545 Spouse/Guest/Exhibitor** *(Conference & Meals)*
☐ **$445 Spouse/Guest/Exhibitor** *(Meals Only)*

☐ $40 CME

☐ $245 only attending on Thursday
☐ $245 only attending on Friday
☐ $245 only attending on Saturday
☐ $95 only attending on Sunday
☐ $95 only attending Banquet Sat. eve
☐ $445 Student (medical/dental) – Full conference
☐ $375 Student--only attending Fri eve – Sun

If you can help with a Student/Resident/Fellow Sponsorship:

☐ $445 Full Student Sponsorship ☐ $_____ Partial Sponsorship of a Student/Resident/Fellow

YOUR PAYMENT OPTIONS:

☐ Check – payable to Christian Medical & Dental Associations (Mark Memo: **WPC 2020 Conference**)

☐ Charge my credit card: ☐ MasterCard ☐ VISA ☐ American Express **Payment Total** $_____

Name on Card: _____ **Billing Address:** _____

Card Number: _____ **City:** _____ **State:** _____ **Zip:** _____

Expiration Date: _____CVV_____ **Signature:** _____**Date**:_____

SUBMIT REGISTRATION *Please make a copy for your records. Then submit original form with payment by email, mail or FAX.*
MAIL: WPC/CMDA, PO Box 7500, Bristol, TN 37621
EMAIL: Debbie.mcalear@cmda.org
FAX: (423) 844-1017 If sent by FAX, please also email to let us know to expect it. Questions? Call Debbie at (423) 844-1022

LATE FEE $100 AFTER AUGUST 24, 2020

CANCELLATION FEE--*Cancellations & requests for refund must be submitted in writing to Christian Medical & Dental Associations. Cancellation charges will be assessed as follows:*

Before August 21, 2020	**$50.00**
On or After Aug. 21, 2020	**No Refund**