

The Practice of Transplant Administration Workshop

September 27 - 28, 2010 ♦ Hotel del Coronado, San Diego, California

Registration Information

- ◆ **Workshop Fee: \$950.00/person**
- ◆ **Venue: Hotel del Coronado, 1500 Orange Avenue, Coronado, CA 92118**
Reservations: (800) 468-3533 or (619) 522-8000
www.hoteldel.com

Special Team Discount

To ensure that your organization does not miss out on any vital information, two or more from the same organization deduct \$100.00 per person from registration fee.

- ◆ **Make reservations before September 3, 2010, as the block of rooms will sell out quickly!**
A block of rooms is set aside at low convention rates. Single or Double: \$242.00/night plus \$25.00/night resort fee. Refer to "Transplant Management Group" to ensure convention rates when making reservations.

- ◆ **Substitutions/Cancellations**
In order to receive a prompt refund, your notice of cancellation must be received in writing ten (10) working days (September 13, 2010) before the workshop. We regret cancellations will not be accepted after that date. However, we will be pleased to transfer your registration to another member of your company at any time. **All cancellations are subject to a \$100.00 processing fee.**

Register Online at www.transplantmanagement.com

Or

Mail Completed Form to:
Transplant Education and Research Institute
Attn: Christine Marshall
11835 Carmel Mountain Road #1304-248
San Diego, CA 92128

Fax Completed Form to:
Transplant Education and Research Institute
Attn: Christine Marshall
(901) 339-2332

For further information: (901) 481-2332 Direct
(877) 868-9170 Toll Free
Email: cmarshall@transplantmanagement.com

NAME _____ TITLE _____

HOSPITAL/COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

EMAIL _____

Check one: I am paying \$ _____ by check. Make check payable to "TERI" (Transplant Education and Research Institute)

I am paying \$ _____ by Credit Card. Check one of the following: Visa MC AMEX

Credit Card # _____ Exp Date ____/____

Address Credit Card is billed to _____

Name on Credit Card _____ Signature _____

Check if applicable:

I will need Nursing Continuing Education Units

I will need Physician Continuing Medical Education Units

NOTE: To confirm your Workshop seat after September 20, 2010, please contact Christine Marshall at (901) 481-2332.