

REGISTRATION FORM



SATELLITE MEETING Cell Lineages, Genetic Instability and Human Disease



University of Washington, Seattle, Washington, USA
August 31–September 2, 2005

Attendees are encouraged to register on-line for the Cell Lineages, Genetic Instability and Human Disease Satellite Meeting. On-line registration is available through the Web site, <http://depts.washington.edu/biowww/ems/>.

Attendees are encouraged to make their housing reservations in advance to ensure availability. Housing is not included in the registration fees.

(Required: Please check the appropriate box) PLEASE PRINT OR TYPE (Black ink only)

First Name/Middle Initial: _____

Last Name: _____ Professional Degree(s): _____

Badge Name Preference: _____

Company Name: _____

Department: _____

Street Address: _____

City: _____ Prov/State: _____ Zip: _____ Country: _____

Area Code/Phone Number: _____ Fax Number: _____

E-mail Address: _____

If you are a student or post-doc registrant, please provide the following information:

Post-Doc Graduate Student Undergraduate Student

Institution: _____ Advisor's Name: _____

Advisor's Phone Number: _____ Advisor's E-mail: _____

All payments must be in U.S. currency. No phone registrations will be accepted.

Payment by check, please send Registration Forms to:
Cell Lineages Registration • Lockbox 4606 • P.O. Box 8508 • Richmond, VA 23285-4606

USPS/Express packages may be mailed to:
EMS Headquarters • Cell Lineages Registration Department • 1821 Michael Faraday Drive, Suite 300 • Reston, VA 20190

Cell Lineages Registration Fees

	Prior to July 1, 2005	After July 2, 2005	
Delegates*	\$300	\$350	\$ _____
Students/Postdoctoral Fellows*	\$250	\$300	\$ _____
Guest-Dinner (Wed.)	\$50	\$60	\$ _____
Guest-Cruise (Thurs.)	\$60	\$70	\$ _____

*Includes all sessions and events.

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Method of Payment

All registrations submitted by hard copy or fax will be processed on-line by EMS staff.

TOTAL DUE \$ _____

Check or Money Order #: _____

Government Purchase Order #: _____ (US Government P.O. Form must be attached)

American Express Discover MasterCard Visa

Credit Card #: _____ Expiration Date: _____

Signature: _____

Cardholder's Printed Name: _____

Special Services

If you require special services, please describe on the line(s) below. For more information about special services, please call EMS Headquarters and ask for Jessi Canning (703) 438-8220 or e-mail at jcanning@ems-us.org.

