Personal Information - PLEASE PRINT CLEARLY FOR BADGE PURPOSES

Surname (First) Name: _____ Family (Last) Name: _____

Address: _____

City: _____ State/Province: _____ Postal Code: _____ Country: _____

Telephone: _____ Fax: _____

E-mail (required): _____

Name As It Should Appear On Badge: _____ Degree: _____

Select Record Type: ☐ Fellow ☐ Resident ☐ Doctor ☐ Company Rep. (Company: _____)

Registration Information		**Price**	**Total**
☐	Meeting Registration – Fellow, Resident, Doctor	US $50	
☐	Meeting Registration – Company Representative	US $100	
Optional - Small Group Surgical Demonstrations of Hip Arthroscopy - Friday, January 26, 2018		**Price**	**Total**
☐	Hip Arthroscopy Model Workshop & Cadaveric Demonstration	US $50	
		GRAND TOTAL	

Method of Payment

☐ Check – *payable to:* ☐ VISA ☐ MasterCard ☐ American Express ☐ Cash (US $ Only)

Santa Monica Orthopaedic and Sports Research Foundation

Card Number: _____ Expiration Date: _____ CCV#: _____

Name (As It Appears On Card): _____

Signature: _____

By submitting this form, attendees allow MCJ Consulting, LLC to charge their credit card for the total registration amount.

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Telephone 925-807-1190 Fax 925-807-1199