

REGISTRATION FORM

2017 Annual Conference on Chiropractic & Pediatrics

November 17-19, 2017, NEW YORK

1st Registrant (First name) _____ Last Name _____ Suffix _____

2nd Registrant (First name) _____ Last Name _____ Suffix _____

Mailing address: _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ Phone: Office Cell _____

Email : *All confirmations will be via email only* _____

Enrolled in _____ Expected year of graduation _____

CHECK YOUR CATEGORY	ADVANCE By Oct 9	REGULAR Oct 10 –Nov 13	LATE Nov 14 - Onsite	YOUR FEE
<input type="checkbox"/> DC	\$ 429	\$ 499	\$ 549	
<input type="checkbox"/> ICA Pediatric Council Member	\$ 399	\$ 469	\$ 519	
<input type="checkbox"/> ICA DC Member	\$ 399	\$ 469	\$ 519	
<input type="checkbox"/> Student	\$ 179	\$ 249	\$ 299	
<input type="checkbox"/> SICA Member	\$ 129	\$ 199	\$ 249	
<input type="checkbox"/> CA/Spouse Non DC	\$ 259	\$ 329	\$ \$379	
<input type="checkbox"/> ICA Lifetime Member (\$35 for CE; \$0 if no CE is required)	\$ 35 for CE	\$ 35 for CE	\$35 for CE	
			TOTAL	\$

I am paying by: Check (make payable to *ICA Pediatrics Council*) Mastercard/Visa Am Express

Credit Card No. _____ Exp Date _____ CVV _____

CANCELLATION POLICY: Money refunded less 15% administrative fee if cancelled by November 13th. After November 13th **NO REFUNDS**. Refunds will be paid after conference. Cancellations should be emailed to: icapediatrics@chiropractic.org . No cancellations accepted by phone.

Your signature _____ Date _____

Note: Your receipt will be your credit card statement. You will receive confirmation of your registration after your credit card is processed. Register by:

FAX: ICA Pediatrics Council at 703-351-7893;

Phone: (1) 571-765-7554

Mail: ICA Council on Chiropractic Pediatrics

6400 Arlington Blvd, Suite 800, Falls Church, VA 22042

Online: www.icapediatrics.com