

**The Western Thoracic Surgical Association 34th Annual Meeting / Kona, Hawaii
REGISTRATION FORM**

Name: _____
 Hospital/Affiliation: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____ Country: _____
 E-Mail: _____ Telephone: _____ Fax: _____
 Spouse/Guest (Registration Fee Required): _____
 Family Registrants (name and age of each child): _____

Registration	EARLY BIRD <i>On or before 5/23/08</i>	STANDARD <i>As of 5/24/08</i>
QTY		
___ A. MEMBER	\$525	\$575
___ B. NON-MEMBER PHYSICIAN	\$625	\$675
___ C. INVITED GUEST PHYSICIAN	\$525	\$575
Invited by: _____		
___ D. RESIDENT*	\$425	\$475
___ E. RESIDENT* <i>(Scientific Session Only)</i>	\$50	\$50
___ F. ALLIED HEALTH	\$425	\$475
___ 1. SPOUSE/GUEST	\$400	\$450

** Must present letter from Chief of Service*

OPTIONAL EVENTS/TOURS	
QTY	
___ 10. Breakfast Session A: Adult Cardiac / Friday, June 27	\$45
___ 11. Breakfast Session B: General Thoracic / Friday, June 27	\$45
___ 12. Breakfast Session C: Congenital Heart Disease / Friday, June 27	\$45
___ 13. Snack & Snorkel Cruise Thursday, June 26 th	___ \$100 Adult ___ \$50 Under 16
___ 14. Samson Fun Run Thursday, June 26 th	N/C
___ 15. Golf Tournament Friday, June 27 th Handicap: _____	\$175
___ 16. Tennis Tournament Friday, June 27 th Level of play: _____	\$50

Family Registration	QTY (Ages 12-21)	QTY (Ages 5-11)
2. New Members' Reception	___ @ \$40	___ @ \$28
3. Luau Theme Dinner	___ @ \$75	___ @ \$45
4. Saturday Luncheon	___ @ \$28	___ @ \$16
5. Kids' Banquet	___ @ \$44	___ @ \$28

No charge for children ages 4 & under

TOTAL FEES: Registration:\$_____ Family Registration:\$_____ Events/Tours:\$_____

TOTAL DUE: _____ Please charge to the following credit card, or see the enclosed check:

- MasterCard Visa American Express Check (Enclosed)

Credit Card Number: _____ Exp. Date: _____ Security Code: _____

Signature: _____ *Your credit card's security code is a 3- or 4- digit number located on the front or back of your credit card.*

Name As It Appears on Credit Card: _____

Billing Address of Card Holder (If not the same as above): _____

If you have a disability which requires special needs or accommodations, please check here and you will be contacted by the Association's Administrative Offices.

*All requests for refunds must be received in writing by June 16, 2008. Requests received after the date will not be honored unless a special request is forwarded to the Secretary/Treasurer. All refunds are subject to a \$50.00 cancellation fee.

Please send this form to: WTSA, 900 Cummings Center, Suite 221-U, Beverly, MA 01915, Fax: 978-524-0498