ALS/MND Nursing and Healthcare Professionals Symposium
November 7 – 10, 2013
Chicago, IL, USA

Registration Form
Attendee Information (Please Print)

Name (As you would like it on your ID Badge) Title

Business Name and Affiliations (Sponsoring Organizations, University, Hospital, etc) # of years in ALS/MND Clinic

Business Mailing Address City State Country Zip Code

Business Phone Business Fax **Email**

Mobile Phone Emergency Contact Name and Number

Please check the following:

- ❑ *Please check here if you have a disability that requires special assistance and we will contact you.*
- ❑ *Please check here if you have special dietary needs and we will contact you.*

Conference Activities: (These activities are included in your registration fee)

- ❑ *I will attend the New Learner Sessions on Thursday, November 7* ***(less than one year of experience)***
- ❑ *I will attend the Symposium Welcome Reception on Thursday, November 7* ***(evening)***
- ❑ *I will attend the Happy Hour Reception on Friday, November 8*
- ❑ *I will attend the Celebration Dinner on Saturday, November 9* ***(location TBD)***

- ❑ I will have guests attend: C**elebration Dinner – Saturday, November 9 _____ @ $40 pp**

Hotel Reservations must be made by each participant prior to **Friday, October 11** to guarantee the conference rate of $159 for a King Bedroom/$179 for a Double Queen. The conference rate is only applicable for nights of November 6 – 9 while quantities last. Please make your reservations early; rooms are not guaranteed. If you are a party of one interested in rooming with other conference attendees, please contact conference planners (cowen@lesturnerals.org).

Registration Options (Please select one):

- ❑ **$159 Early Registration Fee (postmarked on or before September 13)**
- ❑ **$199 Registration Fee (postmarked after September 13)**

Discount offered to those who register 3 or more participants from your local organization or center – 10% off each registration!
No refunds will be giving after October 24.

Please make checks payable to Les Turner ALS Foundation or charge Visa MasterCard Discover Card American Express

Name of Cardholder _____

Card Number _____ "V" Code _____ Expiration Date _____

Signature _____ Amount $ _____

Please mail, email or fax this form with check or credit card information to:

Les Turner ALS Foundation
ATTN: ALS/MND Nursing Symposium
5550 W. Touhy Avenue, Suite 302 • Skokie, IL 60077-3254
847-679-3311 • 888-ALS-1107 (toll-free)
Fax: 847-679-9109
www.LesTurnerALS.org