



REGISTRATION FORM



First Name _____ Middle Initial _____ Last Name _____
 Name of Company (Do Not Abbreviate) _____ ACCWS Member: Yes No
 Address _____
 City _____ State _____ Zip Code _____
 Your Exact Title _____ E-mail _____
 Business Phone _____ Business Fax _____
 Please List Designations: CWS, FACCWS etc: _____

METHOD OF PAYMENT

Credit Card: Amex MC VISA Check: (Payable to The American College of Certified Wound Specialists)
 Credit Card # _____ Exp Date: _____
 Cardholder Name (Print) _____
 Cardholder's Billing Address _____
 City _____ State _____ Zip Code _____
 Signature _____ Date _____
 Print Name (As It Should Appear on Certificate) _____

REGISTRATION FEES

Prices are per person. U.S. funds only. Payment must be included with registration.

| INDIVIDUAL REGISTRATION | | | | |
|---|--------------------------|---------------------------|--------------------------|----------|
| | Mansfield, TX 5/03/08 | Boston, MA Spring 2008 | Altoona, PA Fall 2008 | Subtotal |
| ACCWS Member (\$225 per person) | | | | |
| Non-Member (\$250 per person) | | | | |
| Student (\$175 per person) | | | | |
| PRICING IS DISCOUNTED FOR GROUPS: ACCWS Members \$200 each / Non-Member \$225 / Student \$150 | | | | |
| GROUP REGISTRATION : Groups constitute three (3) or more people submitted together. | | | | |
| 1. NAME: | | | | |
| 2. NAME: | | | | |
| 3. NAME: | | | | |
| 4. NAME: | | | | |
| 5. NAME: | | | | |
| 6. NAME: | | | | |

All cancellations must be in writing. Refunds less 20% administrative charge will be given up to two weeks prior to the event. No refund will be given after that point. Please visit the website for exact locations.

Complete this registration form and fax or mail, with your payment to:

The American College of Certified Wound Specialists
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dabts@theccws.org