



2016 Congenital Adrenal Hyperplasia Patient & Family Summit

(For patients with Classical or Non-Classical CAH & health care professionals) Saturday, November 12, 2016 - 8:30am-5pm

REGISTRATION FORM

Hosted by: Comprehensive Care Center for CAH at Riley Hospital for Children at Indiana University Health, Indianapolis, IN

Name:						
Address:						
Day Phone #:	Em	ail:				
*NEW! Please no	te: There will be free k Registration de	· ·		ildren ages 2 an	d up.	
☐ YES, please reserve s	paces for the 2016 Conf	erence.				
Conference Attendance Fees:	\$20/person □ \$25/profe	essional 🗆 \$30/	couple 🛛 \$40/	family		
am/we are participating as a/an	: 🗆 Parent 🛛 Other Rel	ative 🗆 Affecte	əd Adult 🛛 Me	edical Prof. 🗆 Oth	er	
There are a limited number of sc	holarshins available. If iu	nterested pleas	e email Dina@	caresfoundation	ora	
					-	
Name:	Relationship to	s, including any children (include age) that will require babysitting service Relationship to YOU: CAH Type (Carrier, SWCAH, Unaffecte (Spouse, Parent, Child, etc.) Age (of affected person)			affected, etc.) and	
Yes, I would like to purchase a <u>CA</u>				,		
Note quantity next to size: Adult:		XLG XXLO	G Women's: _	SMMedI	LGX-LG	
PAYMENT D BY CREDIT CA	RD: Select one	VISA	M/C	AMEX		
Name on Card:		Amount (USD): \$				
Card #:		Expirat	tion Date:	/ Security	/ Code:	
Billing Address:						
Signature:						

FAX form with credit card payment to 908-686-2019 or MAIL form with payment to: CARES Foundation, Inc., CARES Conference, 2414 Morris Ave., Suite 110, Union, NJ 07083 Make checks payable to CARES Foundation, Inc. QUESTIONS? Call 866-227-3737 or email: conference@caresfoundation.org. REFUND POLICY: Refund requests must be submitted in writing by fax or email no later than October 30, 2015. Refunds will be issued 2-3 weeks after the event.