



**Undersea & Hyperbaric Medical Society  
2019 Northeast Chapter Meeting  
October 12-13  
REGISTRATION FORM**

Last Name		First Name		Degree	
Address					
City/Town		State/Province			
Postal Code		Country			
Email (must have)		Daytime #			

**Privacy Consent:** In registering for this conference, relevant details (name/address) will be incorporated into a delegate list for the benefit of all delegates, and also may be made available to parties directly related to the conference including accommodation suppliers and sponsors.

**CONSENT TO USE CONTACT DETAILS:**

**YES**, I consent to my details being passed on to a third party or being used for a secondary purpose.  **NO**, I do not consent to my details being passed on to a third party or being used for a secondary purpose

**UHMS MEMBER FEES**

**OCTOBER 12-13**

**PHYSICIAN** (MD/DO/MBBS or Equivalent) / **PHD** (Researcher/Scientist)

SATURDAY: October 12  \$200  
 SUNDAY: October 13  \$100

**FELLOW/RESIDENT / NON-PHYSICIAN** (CHT/CHRN/RN/RRT/DMT/PA, etc.) / **STUDENT**

SATURDAY: October 12  \$160  
 SUNDAY: October 13  \$ 80

**NON-MEMBER FEES**

**OCTOBER 20-21**

**PHYSICIAN** (MD/DO/MBBS or Equivalent) / **PHD** (Researcher/Scientist)

SATURDAY: October 12  \$240  
 SUNDAY: October 13  \$120

**FELLOW/RESIDENT / NON-PHYSICIAN** (CHT/CHRN/RN/RRT/DMT/PA, etc.) / **STUDENT**

SATURDAY: October 12  \$200  
 SUNDAY: October 13  \$100

**Social Functions** (Attendees only)

**YES**, I will be attending the **DECOMPRESSION RECEPTION**: Saturday, 6pm-7pm INCLUDED

**Accompanying Persons** (per person)

**ACCOMPANYING PERSONS**: Additional **DECOMPRESSION RECEPTION** Tickets \_\_\_ x \$40

**TOTAL AMOUNT ENCLOSED OR TO BE CHARGED: \*ALL \$\$ are USD\***

**\$**

CHAPTER CANCELLATION/REFUND POLICY: \$50 administrative fee will be held on all cancellations three (3) months prior to start of meeting date. 50% of fees will be held on all cancellations one (1) month to two weeks prior to start of meeting date. NO REFUNDS two weeks prior to or after the meeting date.

**PAYMENT INFORMATION**

Check/Money Order (make payable to UHMS)  Visa  MasterCard  American Express  Diners  Discover

Card Number		Expiration Date		CVV Code	
Name on Card		Cardholder Signature			
Billing Address		Billing zip code			

**MAIL WITH PAYMENT TO:**

**UHMS, 631 US HIGHWAY 1, SUITE 307, NORTH PALM BEACH, FL 33408  
OR FAX TO: 919-490-5149 / email: [uhms@uhms.org](mailto:uhms@uhms.org) / website: [www.uhms.org](http://www.uhms.org)**