

REGISTRATION INFORMATION: (PLEASE TYPE OR PRINT CLEARLY.)

First: _____ Middle: _____

Last: _____ Credentials: _____

Affiliation/Company Name: _____ Department: _____

Street Address: Home Work _____

City: _____ State/Province: _____ ZIP/Postal Code: _____ Country: _____

Phone: _____ Fax: _____

E-mail (required to obtain CME/CE credit)* _____

Are you a first time attendee? Yes No NKF Member ID (if applicable): _____

PAYMENT PROCESSING:

Payment is accepted by check (made payable to the National Kidney Foundation) or by credit card. International submissions by check must be paid in U.S. dollars by international money order or bank draft drawn on a U.S. bank. All other checks will be returned.

Check # _____

Please charge my: Mastercard Visa American Express Discover

Account #: _____ Expiration Date: _____

Signature: _____ Name of Cardholder (print): _____

PROFESSIONAL STATUS (Please indicate your professional status below.):

- Physician Pharmacist Physician Assistant Nurse Practitioner Nurse Technician Dietitian Social Worker
 General Attendees/Other _____

PLEASE NOTE: There will be a \$20 fee for returned checks. Refund requests must be made in writing and postmarked on or before **March 23, 2010** and are subject to a 10% administrative fee. Requests post-marked after **March 23, 2010** will not be accepted.

ONE-DAY REGISTRATION FEE:

| | |
|--|--|
| <input type="checkbox"/> \$145 – Physician, Pharmacist, & General Attendee/Other | <input type="checkbox"/> \$95 – Advanced Practitioners, Nurses & Technicians, Dietitians, and Social Workers |
| <p>Check the day you will attend:</p> <input type="checkbox"/> Wednesday, April 14 <input type="checkbox"/> Thursday, April 15 <input type="checkbox"/> Friday, April 16 | <p>Check the day you will attend:</p> <input type="checkbox"/> Wednesday, April 14 <input type="checkbox"/> Thursday, April 15 <input type="checkbox"/> Friday, April 16 |

TOTAL (one-day): \$ _____

First: _____ Middle: _____ Last: _____ Phone: _____

TWO-DAY REGISTRATION FEE:

| | |
|--|--|
| <input type="checkbox"/> \$275 – Physician, Pharmacist, Other | <input type="checkbox"/> \$190 – Advanced Practitioners, Nurses & Technicians, Dietitians, and Social Workers |
| Check the two days you will attend: <input type="checkbox"/> Wednesday/Thursday (April 14-15, 2010) <input type="checkbox"/> Thursday/Friday (April 15-16, 2010) | Check the two days you will attend: <input type="checkbox"/> Wednesday/Thursday (April 14-15, 2010) <input type="checkbox"/> Thursday/Friday (April 15-16, 2010) |
| TOTAL (two-day): \$ _____ | |

TO REGISTER:

| | |
|--|--|
| Fax: 212.889.4287 Data Services Department | Mail: National Kidney Foundation GPO 5456 New York, NY 10117-3193 |
|--|--|

We do not provide your e-mail address to other organizations.

Questions: Data Services Department, **888.JOIN.NKF**

FOR INDIVIDUALS WITH DISABILITIES:

If you have a disability and need special arrangements made on-site, please check the box below and a NKF staff member will call you to make arrangements.

Yes, I have a disability and need special arrangements.