

SCVMC & NKF Nephrology Journal Club

June 7, 2016

REGISTRATION

Register by Friday, June 3rd

Name (first and last) _____

Title/Credentials _____

Employer _____

Street Address _____

City _____ State _____ Zip _____

E-mail _____

Phone (_____) _____ Fax (_____) _____

Registration Fees: Physicians: \$25

Physicians in Training: \$10

Medical Students: Free

Method of Payment: (Please print clearly)

Check MasterCard Visa AmEx Discover

Credit Card # _____

CID# _____ Expiration Date _____

Amount to be charged \$ _____

Cardholder's Name (print) _____

Billing Address _____

City _____ State _____ Zip _____

Authorized Signature _____

Entrée Choice:

Chicken

Fish

Vegetarian

Please make all checks payable to **National Kidney Foundation** and mail with registration form to:
National Kidney Foundation, 131 Steuart Street, Suite 425, San Francisco CA 94105

Or securely fax form with credit card information to 415.543.3331 Attn: Danielle Esquivel



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