



THE 31ST ANNUAL CARRELL-KRUSEN NEUROMUSCULAR SYMPOSIUM

Pre-Program - February 18, 2009 Two-day Program - February 19 and 20, 2009

Texas Scottish Rite Hospital for Children | 2222 Welborn Street, Dallas, Texas 75219



REGISTRATION FORM *(Please mark all portions of symposium for which you are you are registering.)*

ONE-DAY PRE-PROGRAM

Wednesday, February 18, 2009 - Carrell-Krusen Neuromuscular Symposium PRE-PROGRAM

- \$40 EARLY REGISTRATION FEE (if received by January 31, 2009)
- \$50 LATE REGISTRATION FEE (if received after January 31, 2009)

NEUROLOGY GRAND ROUNDS

- Everyone must register - Wednesday, February 18, 2009. **Free Grand Rounds.**

LUNCH AFTER NEUROLOGY GRAND ROUNDS

- \$10 (IF NOT REGISTERED FOR CARRELL-KRUSEN SYMPOSIUM)

** Please Note: There will be no banquet this year. Dinner will not be provided.*

TWO-DAY NEUROMUSCULAR SYMPOSIUM PROGRAM

Thursday, February 19, 2009, and Friday, February 20, 2009

- \$150 EARLY REGISTRATION FEE (if received by January 30, 2009)
- \$175 LATE REGISTRATION FEE (if received after January 31, 2009)

TOTAL AMOUNT ENCLOSED: \$ _____ **Please make checks payable to: Texas Scottish Rite Hospital for Children (TSRHC)*

Credit Card Type: VISA MasterCard American Express Discover

Name as it appears on card: _____ Card Number: _____

Expiration Date Month: _____ Year: _____ Security Code: *(on the back of your credit card)* _____

Signature: _____

Are you a first time Carrell-Krusen Neuromuscular Symposium attendee? YES NO

How many Carrell-Krusen Neuromuscular Symposiums have you attended in the past? _____

Please check all meals that you would like to reserve:

Wednesday	<input type="checkbox"/> Continental Breakfast	<input type="checkbox"/> Lunch
Thursday	<input type="checkbox"/> Continental Breakfast	<input type="checkbox"/> Lunch
Friday	<input type="checkbox"/> Continental Breakfast	<input type="checkbox"/> Lunch

*Please note any dietary needs/restrictions: _____

NAME: *(Please print clearly)* _____ DEGREE: _____

OFFICE ADDRESS: _____ CITY/STATE/ZIP: _____

OFFICE PHONE:(_____) _____ FAX:(_____) _____

E-MAIL: _____

Please provide e-mail address. We are attempting to go completely electronic beginning 2010.

REQUIRED ID# for course credit will be the last four digits of your Social Security #: _____

PLEASE CHOOSE ONE:

Do you want CME credits? YES NO

A Certificate of Attendance? YES NO

For additional information, contact Sandy Pacholick:

Phone: (214) 456-5220 Fax: (214) 456-5210

E-mail: sandy.pacholick@utsouthwestern.edu

***Please make checks payable to: Texas Scottish Rite Hospital for Children (TSRHC) & mail to:**

SUSAN T. IANNACCONI, M.D.,
 Division of Pediatric Neurology
 Children's Medical Center – Dallas
 Ambulatory Care Pavilion in Dallas
 2350 Stemmons Freeway, Suite 5074, Dallas, TX 75207

or FAX to: (214) 456-5210 (Secure Fax)

or E-mail a PDF to: sandy.pacholick@utsouthwestern.edu