National Foundation for Infectious Diseases®

REGISTRATION FORM
20TH ANNUAL CONFERENCE ON VACCINE RESEARCH

APRIL 24-26, 2017

BETHESDA NORTH MARRIOTT HOTEL & CONFERENCE CENTER

5701 MARINELLI ROAD, NORTH BETHESDA, MD 20852

Please complete and return this form by email to vaccine@nfid.org

Please print clearly or type:

Last name | First name | Middle initial | Nickname (for badge)

Professional title | Employer

Degree(s) (circle all that apply)

BA BS DO DVM MA MD MPH MS PharmD PhD RN Other (please specify): _____

Mailing Address

City | State | Postal code | Country

Telephone | E-mail address

Primary practice area (circle one)

Biology
Chemistry
Clinical Research
Epidemiology
Immunology
Infectious Diseases
Non-clinical Research
Pediatrics
Public Health
Vaccinology/Virology
Veterinary
Other (please specify): _____

Primary practice setting (circle one)

Academia
Government
Hospital
Industry
Medical
Pharmacy
Private Practice
Public Health
Other (please specify): _____

Continuing Education (CE) credit requested: (circle one)

CME Certificate of Attendance n/a

What percentage of the work day are you involved in direct patient care? (circle one)

0% 1-25% 26-50% 51-75% 76-100%

How did you hear about this conference? (circle all that apply)

CDC Colleague E-mail Mailing NFID Website Previously Attended

Professional Society (please specify): _____

Other (please specify): _____

What was the major determining factor in registering for this conference? (circle one)

Content/Topics Continuing Education Cost Speakers Location Networking

Other (please specify): _____

❑ Do not include my contact information on the Attendee Roster.

SPECIAL NEEDS

Please email any special meeting needs, requirement, or dietary restrictions to: vaccine@nfid.org_____

PAYMENT (circle the amount enclosed)

REGISTRATION TYPE	Early (before 3/13/17)	Regular (after 3/13/17)
General	**$700**	**$800**
Trainee*†	**$450**	**$550**
Daily (select one)	**$375**	**$475**
	❑ MONDAY ❑ TUESDAY ❑ WEDNESDAY	

Early registration, including payment, must be post-marked by March 13, 2017.
For group registrations, please contact NFID at info@nfid.org.

** Includes students, residents, fellows, and nurses.*

† Proof of status must be provided via a letter from your program director or advisor.

❑ Check or money order drawn on US funds **(made payable to NFID)** enclosed in the amount of $ _____

Mail checks to: NFID, 7201 Wisconsin Avenue, Suite 750, Bethesda, MD 20814

❑ Please bill my credit card in the amount of $_____

Select type of card ❑ Visa ❑ MasterCard

Name as printed on card

Card number | Security Code | Expiration date

Signature

Billing address (if different from mailing address)

CANCELLATION POLICY

Refunds, less a $75 administrative fee, will be granted only if written notification is received at NFID prior to 5:00 pm ET on **March 13, 2017**. There will be no refunds for cancellations made after this date. Substitutions will be allowed; however, you must notify NFID in writing prior to **April 24, 2017**. The program organizers reserve the right to cancel this conference at any time. In the event of a cancellation of the conference, the total registration fee paid will be refunded.