



II InterAmerican Congreso on Emergency Medicine
June 11-13, 2008
SHERATON BUENOS AIRES HOTEL & CONVENTION CENTER

ACEP ID

DATE

NAME (Last, First, Middle)

TITLE (MD, DO, RN, NP, LVN, EMT, PARA, PhD, RPh, PharmD, PA, Resident, FACEP)

MAILING ADDRESS

CITY/STATE/ZIP+4

PREFERRED TELEPHONE NUMBER

FAX NUMBER

E-MAIL ADDRESS

_____ Physician \$350.00

_____ Resident, RN, MP, EMT/Paramedic \$200.00

_____ Medical Students \$150.00

PAYMENT METHOD

_____ VISA

_____ MASTER CARD

_____ AMERICAN EXPRESS

CARD NUMBER

Expiration Date

Zip Code of Billing Address

Name as it appears on card