



AMERICAN ACADEMY OF DISABILITY EVALUATING PHYSICIANS™

Mail or Fax this form: AADEP Attn: Registration
223 W Jackson Blvd, Suite 1104, Chicago, IL 60606-6900
Phone: (312) 663-1171 OR (800) 456-6095 Fax: (312) 663-1175
Please note: If you fax your registration form, please do not mail a hard copy

OFFICE USE ONLY

Meeting Code:

Amount charged

\$

DESIGNATED DOCTOR AND PHYSICIAN TRAINING COURSE

PLEASE TYPE OR PRINT CLEARLY

Member Status:

- Fellow Member Non Member Associate Member

First Name: Middle Initial - Name: [Grid]

Last Name: Nickname: [Grid]

Degree/Title: Specialty: [Grid]

Postal Address: [Grid]

City / State / Postal Code: Country: [Grid]

Work Phone: Work Fax: Email: [Grid]

Payment Information: Payment Method: Check Visa MC Amex
Three/Four-Digit Security Code: Exp. Date Signature:

Table with columns: Meeting date(s), Course Title and Location, Pre-registration cut-off date, Registration Status, FEES: Pre-reg, On-site. Includes details for ADVANCED and STANDARD courses.

Emergency Contact Information: Name: Phone:

CANCELLATION POLICY

There is a \$100 service fee for all cancellations received before September 9, 2010. No refunds for cancellations received after September 9, 2010 or for NO SHOWS.