

Please print this form, fill it out and send it back to us using one of the following methods.

**Registration Fee**

\$ 275.00 CDN – on or before August 18, 2017

\$ 290.00 CDN – after August 18, 2017

Student Rate, with valid student card - \$ 175.00 CDN *Please note: student rate is only applicable to full-time student or resident participants. Quoted rate includes GST at 5% GST # 862181419*

**Conference handouts:** if choosing a paper syllabus \$15.00 will be added to your registration fee, a paperless download is free.

- **If paying by Visa or MasterCard or AMEX charge by fax or phone.**  
Please complete this form and fax it to 250-658-6109 or call Nova Clinical Services at 250-658-6056.
- **If paying by cheque:**  
Please complete this registration form and make your cheque payable to “Nova Clinical Services Inc.”

Submit your payment with registration form to:  
Nova Clinical Services Inc.  
575 Brookleigh Rd.  
Victoria, BC  
V8Z 3K1

**Registration Form – BC Digestive Diseases Weekend**

**September 9, 2017**

If paying by Visa, MasterCard or Amex: charge by fax or phone. Please complete this form and fax it to 250-658-6109 or call Nova Clinical Services at 250-658-6056.  
If paying by cheque: Please complete this registration form and make your cheque payable to: Nova Clinical Services Inc.  
Submit your payment with registration form to: Nova Clinical Services Inc., 575 Brookleigh Rd. Victoria, BC V8Z 3K1

**Registration Fee**

\$ 275.00 CDN – on or before August 18, 2017 (\$290.00 with paper syllabus)  
\$ 290.00 CDN – after August 18, 2017 (\$305.00 with paper syllabus)  
\$ 175.00 CDN – Student Rate (with valid student card) (\$190.00 with syllabus)  
*Please note that the student rate is only applicable to full-time student or resident participants.*  
*Quoted rate includes GST at 5% GST # 862181419*

**Method of Payment**

- Cheque payable to Nova Clinical Services Inc.  
 VISA       MasterCard       Amex

Name on Credit Card: \_\_\_\_\_

Card #: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

Signature: \_\_\_\_\_

- Please tick this box if you do not want your name to be included on the attendee list available to conference participants

Name \_\_\_\_\_  
*(as you would like it to appear on your name badge and receipt)*

- |  |   |
|--|---|
| <input type="checkbox"/> Physician (Family Practice) | <input type="checkbox"/> Specialist (Royal College) |
| <input type="checkbox"/> Nurse                       | <input type="checkbox"/> Pharmacist                 |
| <input type="checkbox"/> Other _____                 | <input type="checkbox"/> Student/Medical Resident   |

CME Credits and Certificate of Attendance will be provided.

**Please indicate which 1 Breakfast with the Experts Sessions you wish to attend:**  
*(Please see Program listing for topics)*  
 1       2       3       None

**Please indicate which 3 of the 5 Breakout Sessions you wish to attend:**  
*(Please see Program listing for topics)*  
 A       B       C       D       E

**Conference handouts:** if choosing a paper syllabus \$15.00 will be added to your registration fee.  
 Download (Paperless, Free)       Paper Bound Syllabus (\$15.00)

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_