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

Registration Fees

Physicians, Pharmacists & Nurse Practitioners:	Nurses & Allied Health
$ 285.00 CDN – on or before April 3, 2020 $ 305.00 CDN – after April 3, 2020	$185.00 CDN – on or before April 3, 2020 $205.00 CDN – after April 3, 2020
Student/ Resident $110.00 on or before April 3, 2020 $130.00 after April 3, 2020 (proof of student status required on-site) Student rate is only applicable to full-time students or residents	

Conference handouts: a paperless download is included in your registration. Paper bound syllabus is no longer available.

- **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

April 25, 2020

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 Fees (See Above)

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

CME Credits and Certificate of Attendance will be emailed to you at the conference.

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

☐ Physician (Family Practice) ☐ Specialist (Royal College)
☐ Nurse ☐ Pharmacist
☐ Other ____________ ☐ Student/Medical Resident

Please indicate if you will attend Breakfast with the Expert: Yes No

Please indicate which 3 of the 6 Breakout Sessions you wish to attend:
(Please see Program listing for topics)

☐ **A** ☐ **B** ☐ **C** ☐ **D** ☐ **E** ☐ **F**

Conference handouts: are now electronic only

Address: ____________________

City: ____________ Province: ____________

Postal Code: ____________

Phone: ____________ Fax: ____________

Email Address: ____________________