

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

Registration Fee

\$ 200.00 CDN – on or before October 15, 2021

\$ 225.00 CDN – after October 15, 2021

Student Rate, with valid student card - \$ 100.00 CDN

Please note that student rate is only applicable to full-time student or resident participants.

Quoted rate includes GST at 5% # 862181419

- **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

A VIRTUAL CONFERENCE IN 2021

Registration Form – Infectious Diseases Update Conference

November 5 & 6, 2021

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

\$ 200.00 CDN – on or before October 15, 2021

\$ 225.00 CDN – after October 15, 2021

\$ 100.00 CDN – Student Rate (with valid student card)

Please note that student rate is only applicable to full-time student or medical resident participants.

Quoted rate includes GST at 5% # 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 credits and receipt)

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

CME credits / Certificate of Attendance will be provided after the event

Address: _____

City: _____ Province: _____

Postal Code: _____

Phone: _____ Fax: _____

Email Address: _____