



# Aesthetic Medicine Symposium

Please complete and Fax (toll-free) to: 1-800-485-5759

OR Scan and email to [info@theiapam.com](mailto:info@theiapam.com)

SYMPOSIUM DATE:		HOW DID YOU HEAR ABOUT THE SYMPOSIUM:	
NAME (As you would like it shown on the Certificate, for NPs: please be specific for designation):			
LAST:	FIRST:	MIDDLE INITIAL:	MEDICAL DESIGNATION(S):
PREFERRED ADDRESS: <input type="checkbox"/> Home <input type="checkbox"/> Practice			
STREET:	CITY:	STATE:	ZIP CODE:
CELL PHONE:	EMAIL ADDRESS:		
PRACTICE NAME:			
PRACTICE ADDRESS (if not entered above):			
STREET:	CITY:	STATE:	ZIP CODE:
PRACTICE TELEPHONE:	SPECIALITY/BOARD CERTIFICATION:		
MEDICAL LICENSE #:	STATE/JURISTICTION:	EXPIRATION:	
SYMPOSIUM OPTIONS (Primary):	<input type="checkbox"/> \$295 - I want to join the IAPAM as an <i>Accredited Member</i> today to get the following discounts on training <input type="checkbox"/> \$3595 (save \$3090) - 4 day Practice Accelerator Program (Aesthetics, Medical Weight Management & Business) - Fri – Mon <input type="checkbox"/> \$2995 (Save \$1695) – 3 day Aesthetic Medicine With Business Tools - Sat – Mon <input type="checkbox"/> \$2995 (Save \$2395) – 3 Day Aesthetic Medicine With Medical Weight Loss - Fri – Sun <input type="checkbox"/> \$2395 (save \$1000)– 2 Day Aesthetic Medicine only - Sat-Sun only <input type="checkbox"/> \$1195 (save \$800) – 1 Day Medical Weight Management only - Friday only		
	<input type="checkbox"/> \$2595 (Save \$2090) 4 day Practice Accelerator Program - <b>Injector</b> - # of attendees _____ <input type="checkbox"/> \$2095 (Save \$2590) 4 day Practice Accelerator Program - <b>Non-Injector</b> - # of attendees _____ <input type="checkbox"/> \$2195 (Save \$995) – 3 day Aesthetic Medicine With Business Tools Sat – Mon – <b>Injector</b> # of attendees _____ <input type="checkbox"/> \$1695 (Save \$1495) – 3 day Aesthetic Medicine With Business Tools Sat – Mon – <b>Non-Injector</b> # of attendees _____ <input type="checkbox"/> \$2195 (Save \$1495) – 3 Day Aesthetic Medicine With Medical Weight Loss Fri – Sun <b>Injector</b> # of attendees _____ <input type="checkbox"/> \$1695 (Save \$1995) – 3 Day Aesthetic Medicine With Medical Weight Loss Fri – Sun <b>Non-Injector</b> # of attendees _____ <input type="checkbox"/> \$1695 (Save \$1700) – 2 Day Aesthetic Medicine only Sat Sun <b>Injector</b> # of attendees _____ <input type="checkbox"/> \$1195 (Save \$2200) – 2 Day Aesthetic Medicine only Sat Sun <b>Non-Injector</b> # of attendees _____ <input type="checkbox"/> \$695 (Save \$800) – 1 Day Medical Weight Management only Friday # of attendees _____		
Additional Attendees (if applicable): <b>Injector price</b> (Must be minimum RN) <b>Admin/Non Injector</b>			
<b>ADDITIONAL ATTENDEES : NAME &amp; MEDICAL DESIGNATION (for certificate) / UNIQUE EMAIL ADDRESS/ PROGRAM ATTENDING FOR EACH PERSON:</b>			
PAYMENT TYPE: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discovery <input type="checkbox"/> Debit Visa <input type="checkbox"/> Debit MasterCard (Debit only for US residents)			
CARD NUMBER:	EXPIRY DATE:	CARD VERIFICATION NUMBER:	
PAID	/ (mm/yr)	(3 digit number on back of card after the card number)	
NAME AS IT APPEARS ON CREDIT CARD:			

\* PLEASE NOTE: YOU WILL RECEIVE A CHARGE ON YOUR CREDIT CARD STATEMENT FROM: IAPAM

**CANCELLATION POLICY:**

Once your payment has been received and processed, you will receive an e-mail confirmation. If for some reason you cannot attend the symposium you must give at least 7 days notice to receive a full credit for a future symposium, no refunds will be given. If for some unforeseen the symposium is cancelled, you will receive a full refund limited to the registration fees already paid. The IAPAM is not responsible for non-refundable airline tickets, related travel costs, hotel accommodations purchased, or any other out of pocket expense you may incur. Symposium locations, agendas, and speakers are subject to change.

I hereby affirm that the information provided on this application is true, current, and correct. This symposium attendance is limited to active licensed physicians (i.e. MD, DO) in good standing. We reserve the right to refuse registration from any attendee. You hereby release all persons and entities, including the IAPAM, their employees and agents, from any liability they might incur for their acts, omissions, and/or communications arising from this application, to the extent those acts, omissions and/or communications are protected by state, federal and/or international law. I understand and agree to the terms of the IAPAM's Privacy Policy that can be found on the IAPAM's website. I hereby authorize the IAPAM and PCA to charge my credit card that I have listed above, for the amounts indicated. The IAPAM is not responsible for additional credit card charges your bank may charge.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_