CMR Northwestern Registration Form

October 11-13, 2017

Last Name:_____ First Name:_____

Credentials:_____

Institution:_____

Street Address:_____

City, State:_____ Zip Code:_____

Daytime Phone:_____Fax:_____

Email Address:_____

Please indicate any special needs:_____

Please indicate any dietary needs: _____

Person Responsible for Payment:

Last Name:_____ First Name:_____

Institution:_____

Street Address:_____

City, State:_____ Zip Code:_____

Daytime Phone:_____ Fax:_____

Email Address:_____

The registration fee is $3,000, payable by check to Northwestern University. If payment is not received within three weeks of receiving the registration form, your registration may be canceled.

Please remit registration form and payment to:

CMR Northwestern
Department of Radiology
737 N. Michigan Ave., Suite 1600
Chicago Illinois, 60611
Phone: (312) 695-2956
Fax: (312) 926-5991
Email: julie.blaisdell@northwestern.edu