



Health Professions Network Meeting Registration Form

[] Yes, my organization will attend the HPN meeting in Minneapolis, MN, April 26 – 29, 2007. Enclosed is a \$150/person registration fee for each individual attending the meeting. (Note: Make checks payable to the Society of Nuclear Medicine, and please indicate that the check is for the HPN in the memo section.)

At this time we anticipate the following individual(s) will attend:

Name: _____ Title: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

E-Mail: _____

First time attendee: [] Yes [] No

Name: _____ Title: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

E-Mail: _____

First time attendee: [] Yes [] No

Please list the top issues affecting your profession, organization or association below:

Housing Request: [] Non-smoking [] Smoking
Do wish to extend your stay? [] Yes [] No If so, what will be the dates of your stay? _____
_____ (Please note that if you wish to extend your stay you will be responsible for the extra days of stay.

[] Sorry, my organization's President, Executive Director or delegate cannot come to the HPN Meeting.

Person's full name filling out this form: _____

HPN/HOSA Scholarship Contribution
(Suggested Amount \$25-\$50)

[] Yes, I would like to contribute to the HPN/HOSA Scholarship in the amount of \$ _____.

Total Amount Enclosed \$ _____