



**CAMS 56<sup>TH</sup> ANNUAL SCIENTIFIC CONFERENCE**  
SATURDAY, NOVEMBER 2, 2019 | PIER 60 AT CHELSEA PIERS, NEW YORK, NY

M.D.    D.O.    P.A.    M.P.H.    R.N.    N.P.    I am a medical student.    OTHER \_\_\_\_\_

LAST NAME:

FIRST NAME:

MAILING ADDRESS:

CITY:

STATE:

ZIP:

CELLPHONE\*:

FAX:

PREFERRED CONTACT EMAIL\*\*:

SPECIALTY :

AFFILIATION (HOSPITAL, SCHOOL OR BUSINESS):

*Registration is required for all participants. Participants must also register in person the day of the event and complete an online evaluation in order to receive CME credit from our accreditation provider.*

*\*Required for CME \*\*Please provide a valid e-mail address. Your meeting registration ticket will be sent to you by e-mail.*

**REGISTRATION TYPE:** CAMS Member \$80    Non-CAMS Member \$160    CAMS Senior Member\*\* FREE    CAIPA Member\* Medical Student-\$40\*\*\*    Resident or Fellow \$40    Nurse \$40

\*CAIPA Member's Registration Fee to be covered by CAIPA. Your CAMS Membership must be in good standing in order to qualify. Any CAIPA member that registers and does not attend the conference will be charged an \$80 no-show fee by CAIPA. You may cancel your registration up to 1 week prior to Annual Conference with no penalty.

\*\* Senior Members are active members of the Society who no longer engage in active clinical or academic work. No CME will be provided.

\*\*\* Registration Fee for Medical Students is refundable if student attends. The pre-registration fee is non-refundable if the student does not attend. You may cancel your registration up to 1 week prior to the Annual Conference with no penalty. Student walk-in registration is \$40 and non-refundable.

**PLEASE CHECK ALL THAT APPLY:** I will be joining for lunch on 11/02/2019 Meeting Registration Fee \$ \_\_\_\_\_ I am unable to attend, but wish to make a contribution \$ \_\_\_\_\_**Total Due:** \$ \_\_\_\_\_**THE DEADLINE FOR MEETING REGISTRATION IS OCTOBER 15, 2019** My payment in the amount of \$ \_\_\_\_\_ is enclosed. **Please make all checks payable to: Chinese American Medical Society****PLEASE CHARGE MY:**

Name On Card: \_\_\_\_\_

Card number: \_\_\_\_\_

Card Expiration Date (MO/YR): \_\_\_\_\_ / \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_ Security Code: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

**MAIL TO:**

CAMS Annual Meeting

11 East Broadway, Unit 4C, New York, NY 10038

**REGISTRATION FORMS CAN BE FAXED TO:**

646.304.6373

**IF YOU HAVE ANY QUESTIONS PLEASE****CONTACT OUR OFFICE AT:**

212.334.4760