



ICPHSO EIN #: 52-2048606

ICPHSO - 4th European Meeting and Training Symposium

November 18th and 19th, 2008

Charlemagne Building
170 Rue de la Loi (Wetsraat)
BE-1049 Brussels, Belgium

ALL ATTENDEES MUST REGISTER!

CONFERENCE REGISTRATION FORM

Registration Type	Early Bird July - Sept 30, 2008	Regular Oct 1st - Nov 17th 2008	Amount
ICPHSO Member	\$300.00	\$350.00	
Non Member	\$350.00	\$400.00	
ICPHSO Member Benefit Discount *(See note below)	\$150.00	\$200.00	
ICPHSO Additional Member Benefit Discount *(See note below)	\$250.00	\$300.00	
Are you a Speaker or Moderator	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Are you registering as a Government Official	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/C
Will you be attending the "Monday Night Reception" <i>Nov. 17th, at the Berlaymont Building</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/C
Will you be attending the "Tuesday Night Dinner" <i>Nov. 18th, at the Sofitel Hotel</i> <i>This dinner has limited availability. Seating will be filled on a first come basis.</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/C
Total Amount Due			

All registrations include: Two Breakfasts, Two Lunches, One Reception, One Dinner and all breaks.

* You must be an ICPHSO Business Member or an ICPHSO Additional Business Member to take advantage of this one time discount option.

Cancellation Policy: A full refund will be given with a written notification 5 weeks prior to the event. A 50% refund will be given with a written notification 2 weeks prior to the event. No refund will be given after November 17th, 2008. Cancellation written requests should be sent to ICPHSO Registration Manager, Bonnie Kuchinski at b.kuchinski@icphso.org.

ATTENDEE INFORMATION

Please enter your information, as you would like it to appear on your name badge and in the attendee directory

First Name: _____ Last Name: _____

Company: _____

Title: _____

Address: _____ City: _____

State: _____ Country: _____ Postal Code: _____

Work Phone: _____ Work Fax: _____

E-mail: _____

PAYMENT INFORMATION

Check Please make check payable in U.S dollars to: ICPHSO

Visa MasterCard American Express Discover

Credit Card Holders Information

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Country: _____ Postal Code: _____

Credit Card Number: _____

Exp Date: _____ Sec Code: _____

Signature of Card Holder: _____

Hotel Information

For Hotel information and reservations, please go to our Website

Print this form, attach payment or fill out payment information and submit to:

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Oak Creek, WI 53154
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Fax: (414) 768-8001
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