



# Irish-American Orthopaedic Society 2019 ORTHOPAEDIC CONFERENCE

**SEPTEMBER 6-7, 2019 • SEA CREST BEACH HOTEL • CAPE COD, MASSACHUSETTS**  
 Online: [www.ioas.net](http://www.ioas.net) • Phone: 1-877-441-9103 • Fax: 410-494-0926



NAME	DEGREE	SUB-SPECIALTY
COMPANY/INSTITUTION	DEPARTMENT	
ADDRESS	CITY	STATE      ZIP
OFFICE PHONE	EMAIL ADDRESS	

**Physician/Allied Health Registration Fee Includes:** Scientific Sessions, Continental Breakfasts, Breaks, Lunches, Welcome Reception, and President's Dinner

**Spouse/Guest Registration Fee Includes:** Continental Breakfasts, Lunches, Welcome Reception, and President's Dinner

**Child Registration Fee Includes:** Continental Breakfasts, Lunches, Welcome Reception, and President's Dinner

#	Registrant Category	Early Bird Fee (through 8/5/19)	Regular Fee
	IAOS Member Physician	\$395	\$495
	Non Member Physician	\$595	\$695
	Speaker/Presenter	\$395	\$395
	Emeritus Member	\$250	\$300
	Allied Health Professional	\$200	\$250
	Resident/Fellow Presenter	\$100	\$100
	Resident/Fellow	\$125	\$150
	IAOS 2019 Membership Dues (if not current)	\$150 Physician \$75 Allied Health or Emeritus	

#	Guest Category	Early Bird Fee (through 8/5/19)	Regular Fee
	Spouse/Guest (18+)	\$175	\$200
	Child(ren) 5-17 years	\$35	\$35
	Child(ren) under 5 years	No Charge	No Charge

Please provide the information below for each of your adult guests so we can include their name badges in your registration packet. Registered children, ages 5-17, will receive a wristband.

Spouse/Guest Name	City	State
Guest Name	City	State
Guest Name	City	State
Guest Name	City	State

**CANCELLATION POLICY:** Full refund (less \$50.00 administrative fee) will be granted if a cancellation is made prior to 10 business days before the meeting date; a 50% refund if canceled between 5 and 10 business days before the meeting date. No refund will be granted within 5 business days of the meeting, or anytime thereafter.

**SPECIAL NEEDS:** If you have hearing, vision, or mobility impairment and need appropriate accommodations in order to participate fully in these activities, please check here and notify us by August 15, 2019. You will be contacted by the DTMS Management Company to discuss your needs.

#	Tours/Activities (includes transportation)	Fee(s)
	John F. Kennedy Hyannis Museum Tour (Friday 9 a.m.)	Adult \$38 Child 5-7 \$32 Child 1-4 Free
	Cape Cod Coffee & Winery Tours & Tastings (Must be 21+ years for wine tasting) (Friday Coffee 10 a.m. / Wine 12 noon)	Adult \$45 Child 5-7 \$30 Child 1-4 Free
	Lobster Cooking Demo and Tasting by renowned culinary chef (Saturday 2 p.m.)	\$50 per Person
	9-Hole Golf Tournament at The Cape Golf Club (Sat. 2 p.m.) *Club rental is available for an additional \$35	\$75 per Person*
	18-Hole Golf Tournament at The Falmouth Country Club - only 8 slots available (Sunday 9 a.m.) *Club rental is available for an additional \$25	\$100 per Person*
	Sea Dog Deep Sea Striper Fishing - only 6 slots available (Sunday 6 a.m.)	\$150 per Person
	Downtown Falmouth Shopping (Sunday 10 a.m.)	\$20 per Person

**TOUR/ACTIVITY TICKET CANCELLATION POLICY:** Full refund will be granted if a cancellation is made prior to 30 business days before the meeting date. No refund will be guaranteed within 30 business days of the meeting. IAOS will attempt to sell unwanted tickets on a first-come, first-served basis. If IAOS successfully sells your unwanted ticket, you will receive a full refund of the ticket cost. IAOS reserves the right to cancel an activity if the minimum number of participants has not purchased tickets prior to 30 business days before the meeting date.

**Physician/Allied Health Registration Fee \$** \_\_\_\_\_  
**Physician Speaker/Presenter Registration Fee \$** \_\_\_\_\_  
**Resident/Fellow Registration Fee \$** \_\_\_\_\_  
**Resident/Fellow Speaker Registration Fee \$** \_\_\_\_\_  
**Spouse/Guest/Child Registration Fee(s) \$** \_\_\_\_\_  
**Tours/Activities Fees \$** \_\_\_\_\_  
**IAOS 2019 Membership Dues \$** \_\_\_\_\_  
**TOTAL \$** \_\_\_\_\_

Check Enclosed (payable to Irish-American Orthopaedic Society)  
 Charge my:     Visa     MasterCard     American Express

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_ CVV \_\_\_\_\_

Name on Card \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_