

2020 AADSM ANNUAL MEETING REGISTRATION FORM



Section 1 – Registration Information (type or print clearly)			
Name: (This will appear on the badge)			Degree(s):
Company:			
Address:			
City:	State:	Zip Code:	Country:
Telephone:	Email: (Required to receive confirmation)		
On-Site Mobile Number (Emergency Only):			
Is this your first time attending an AADSM Annual Meeting: Yes No			

Section 2 – Registration Types*	On or before 4/10	4/11 - 5/22
AADSM Member	\$550	\$600
AADSM Member – Active Duty Military	\$140	\$150
AADSM Student Member	\$60	\$60
Dental Staff of AADSM Member Employer's Name: Employer's Email:	\$275	\$325
Nonmember	\$725	\$775
Guest – Guest Name: (Family members only, guests must be 16 years of age, access to exhibit hall only)	\$50	\$50
* Includes admittance to general sessions, President's Reception and the exhibit hall. General registration does not include Meet the Professor lunch sessions.		
Section 2 Total: \$		

Section 3 – Membership Dues: Not a member? Check a box below to join today and register for the meeting at the member rate.
Regular Membership: \$400**
Student Membership: Free (With completion of Student! Membership Application)
Section 3 Total: \$
** A copy of a valid dental/medical license must be submitted. Membership will be valid through December 31, 2020.

Section 4 – Lunch Sessions: Friday, May 29 – Saturday, May 30		
	Member	Nonmember
Friday, May 29 Meet the Professor: _____ (Please write in choice of M01 - M04 above)	\$90	\$100
Saturday, May 30 Meet the Professor: _____ (Please write in choice of M05 - M08 above)	\$90	\$100
Section 4 Total: \$		

Meet the Professor lunch sessions are an additional fee. You must be registered for the general session to attend these sessions. Advanced registration is strongly encouraged; space is limited and sold on a first-come, first-served basis.

Grand Total (Please total sections 2-4)	\$
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Section 5 – Payment Method		
<input type="checkbox"/> Check: Make payable to the AADSM (U.S. funds drawn on a U.S. bank)	Credit Card: (check one) <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> American Express <input type="checkbox"/> Discover	
Cardholder Name:		
Card Number:	Exp. Date:	Validation Code:
Billing Address Zip Code:		
Signature:		Date:

By submitting this registration form, the registrant/payer agrees to abide by the policies and disclaimers stated on the AADSM website.

PLEASE SUBMIT COMPLETED
REGISTRATION FORM VIA:

Fax:
(630) 686-9876

OR

Mail:
American Academy of Dental Sleep Medicine,
1001 Warrenville Rd., Ste. 175, Lisle, IL 60532