

(Fax this portion – please print clearly)

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

Credit Card Billing Address (if different from mailing address):

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

Day Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Fee: \$2000 (circle one) Check Visa MasterCard

Card Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Security Code: \_\_\_\_

Exp: \_\_\_\_ / \_\_\_\_ Signature: \_\_\_\_\_

*Please make check payable to “Current Issues in MRI” and mail to:*

***Current Issues in MRI Orthopaedic Workshop, 170 Madrona Avenue, Belvedere, CA 94920***

*A \$100 service charge will be made on refunds requested in writing prior to July 29, 2011. No refunds will be provided after July 29, 2011.*