Genetic Aortic Disorders Association Canada

Heritable Aortic Disease Conference

Patients & Families

Saturday, September 17, 2016
8:00 a.m. – 12:00 p.m.
BMO Conference Center, Toronto Western Hospital, Toronto, Ontario

Please fill out this form and return to the below listed mailing address or email to info@gadacanada.ca

*** Required Details for all registrants.**

REGISTRANT 1:

_____
***Name (First, Last)**

***Address:** _____

***City:** _____ ***Province/State:** _____ ***Postal/Zip:** _____ ***Country:** _____

***Primary Phone:** _____ ***Email:** _____
work / cell / home

***How did you hear about this conference:**

☐ **Email** ☐ **GADA website**
☐ **Clinic** ☐ **Word of mouth**
☐ **Social media** ☐ **Other**

*** Is this your first GADA (previously CMA) conference:** ☐ **Yes** ☐ **No**

*** Food Preference & Allergies:** ☐ **None**

☐ **Yes, please specify** _____

***Please indicate your first, second and third choice of workshops you would like to attend:**

Genetics: _____ **Cardiology:** _____ **Aortic Surgery:** _____

ADDITIONAL REGISTRANTS: Print & attach a separate sheet if more than 2 additional registrants

** Use this section to enter the names of additional family members, adults (over 18 years) or children/youth (under 18 years) who will be attending the conference.

** Any member, including affected and unaffected siblings, attending the conference must be registered.

** Please note that child care will not be provided.

REGISTRANT 2:

_____ _____
*** Name (First, Last)** ***Relationship to registrant 1**

***Address:** _____

***City:** _____ ***Province/State:** _____ ***Postal/Zip:** _____ ***Country:** _____

***Primary Phone:** _____ ***Email:** _____
work / cell / home

Is this your first GADA (previously CMA) conference: ☐ **Yes** ☐ **No**

*** Food Preference & Allergies:** ☐ **None**

☐ **Yes, please specify** _____

***Please indicate your first, second and third choice of workshops you would like to attend:**

Genetics: _____ **Cardiology:** _____ **Aortic Surgery:** _____

REGISTRANT 3:

_____ _____
*Name *Relationship to registrant 1

***Address:** _____

***City:** _____ ***Province/State:** _____ ***Postal/Zip:** _____ ***Country:** _____

***Primary Phone:** _____ ***Email:** _____
work / cell / home

Is this your first GADA / CMA conference: ☐ **Yes** ☐ **No**

*** Food Preference & Allergies:** ☐ **None**

☐ **Yes, please specify** _____

***Please indicate your first, second and third choice of workshops you would like to attend:**

Genetics: _____ **Cardiology:** _____ **Aortic Surgery:** _____

Heritable Aortic Disease Conference
Patients & Families
Saturday, September 17, 2016. 8:00 a.m. – 12:00 p.m.

***Total registrants attending the conference:** _____

***Registration Fee**: **children under 18 years are free**

_____ **x $ 50 per participant over 18 years of age** *(breakfast and refreshments included)*
Number of participants over 18 years old

I would like to make a donation of: $_____

Donations $25 or greater are eligible for a tax receipt

***Total Payment: $**_____

☐ Cheque enclosed, made payable to the **Genetic Aortic Disorders Association Canada**

☐ Visa or MC #: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Exp. Date: ☐☐ ☐☐

Name on card: _____

Would you like to volunteer at the conference: ☐ **Yes** ☐ **No**

*Registrations and payment must be submitted by September 9, 2016.

*Cancellation Policy: There will be a $15 administration fee for any conference cancellations. No refunds after September 9, 2016.

Thank you for your support! We look forward to meeting you at the conference!

Mail to: Genetic Aortic Disorders Association Canada

Centre Plaza Postal Outlet, 128 Queen St. S. P.O. Box 42257,

Mississauga, ON L5M 4Z0

Tel.: (905) 826-3223 or (866) 722-1722

www.gadacanada.ca • Email: info@gadacanada.ca