VII Midwest Blood Club Meeting
Annual Meeting Registration Form

April 30-May 1, 2009
Cincinnati Children's Hospital Medical Center
Experimental Hematology and Cancer Biology

Please type or print legibly – this information will be used to create your name badge.

Name: ____ Degree: __________

Institution: ____

Address: ____

City: ____________________________ State: _______ Zip Code: ______

E-mail: ____

Telephone: ___________________________ Fax: _________________________

Payment Information

Registration Fee: $70.00

Please Indicate Form of Payment: (Please do not send cash.)

Check Enclosed Visa MasterCard American Express

Credit Card Payments
Credit Card Number: ____

Credit Card Expiration Date: ____

Card Holder's Name: ____
(Please print)

Card Holder's Signature: ____

Check Payments
Make Check Payable to Cincinnati Children's Hospital Medical Center

Mail or fax to: Attn: Kristie Gilb
Cincinnati Children's Hospital Medical Center
Division of Experimental Hematology
Mail Location 7013, TCHRF 7566AA
Cincinnati, OH 45229
Fax: 513 636 3768

Note: Please be sure to check our website for details regarding hotel accommodations.