

REGISTRATION FORM

Register Online - www.stgeorges.org.nz

Please complete this form, take a copy for your records and forward it to:
International Pelvic Floor Symposium, C/-
Conference Innovators Ltd, PO Box 7191, Sydenham, Christchurch 8240, New Zealand
Facsimile: +64 3 379 0460 Email joy@conference.co.nz

Tax Invoice - GST Registration Number 10 386 969

Please make cheques payable to: St George's Hospital Inc.

Please note the increase in delegate registration fees from ????????

Payment required with form.

Delegate
Surname _____ Title (Prof/Dr/Mr/Mrs/Miss/Ms) _____ First Name _____
Organisation _____ Position _____
Postal Address _____
City/Country _____ Post Code _____
Email _____
Telephone () _____ Facsimile () _____ Mobile () _____
Special requirements eg dietary, disabilities etc _____

The Privacy Act 1993 provides that, before your name and address details can be published in the list of delegates either for distribution to fellow delegates or any other party, you must give your consent. **If you DO NOT wish your name, address and details to be included in the list of delegates please tick the box** ☐

Registration Fees

Early Bird
until ??????? (NZ\$) \$475 from ??????? (NZ\$) \$550 \$ _____

Registration Fees sub total (inclusive of Goods & Services Tax) \$ _____

Name for name badge (if different from above) _____

Social Functions

(Note that one ticket to Networking function is included in the Symposium registration fee). To assist with catering numbers please indicate if you are attending.

Networking function (Thursday) **one ticket included in registration fee**
☐ I will be attending
Additional ticket(s) Networking function _____ @ \$45 \$ _____

Symposium dinner (Thursday) **NOT included in registration fee**
☐ I will be attending
Total number of ticket(s) Symposium dinner _____ @\$120 \$ _____

Social Functions sub total (inclusive of Goods & Services Tax)\$ _____

Payment Summary

Method of Payment (please circle)	Credit Card	Cheque
	Registration Fees	\$ _____
	Social Functions	\$ _____
	Total (New Zealand dollars)	\$ _____

Please make cheques payable to St George's Hospital Inc

Credit Card Authorisation

If paying by credit card please circle the card to be charged: Mastercard | Visa

Card Number _____ / _____ / _____ / _____

Expiry Date _____ / _____

Cardholder's Name _____

Card Billing Address (if different from address given above)

Signature _____ Date _____

Cancellation Policy:

All cancellations must be made in writing to the Symposium Administrator c/-Joy Mehlhopt, Conference Innovators Ltd, P O Box 7191, Christchurch or email: joy@conference.co.nz. Cancellations made prior to ?????????? will be refunded, less a \$50 administration charge. After this date no refunds will be allowed. All refunds will be processed post-conference. You may re-assign your registration at any time at no additional cost.