CONFERENCE REGISTRATION FORM

Deadline to Register: Friday, September 13, 2019 (or until max occupancy)

(Please Print)

Today's date:			
REGISTREE INFORMATION			
Last name: First:		❑ MD ❑ PhD ❑ Other _____	Phone no.: ( )
Email address:		Position & Institution:	
Street address:	City/State:	ZIP Code:	Country:

	Nonmember	Basic Member*	Premium Member**
Post-Doc/Trainee	❑ $200 USD	❑ $175 USD	❑ $100 USD
Academic/Government/Non-Trainee	❑ $350 USD	❑ $300 USD	❑ $175 USD
Industry	❑ $750 USD	❑ $450 USD	❑ $250 USD
	Attending: ❑ Day 1 ❑ Day 2 ❑ Both Days (Fee covers both days)		

*Basic– FREE, quarterly newsletter

****Premium – FEE, quarterly newsletter, 50% discount on future conference registration fee, access to speaker-approved *Precision Vaccines Conference* videos/slides ~Please see membership form to join~**

CHECK INFORMATION

Please make checks out to Boston Children's Hospital in US Dollars (USD)
Checks are due by Friday, September 13, 2019

Please mail checks to:	ATTN: Maria Crenshaw Boston Children's Hospital 300 Longwood Ave, BCH 3104 Boston, MA 02115

CREDIT CARD INFORMATION

Will accept credit card information by phone. Please call Diana Vo at +1 617-919-6978

_____ _____

BCH FUNDS

Project ID/Fund	Bud. Ref.

_____ _____

Fund Approver signature (above) *Date (above)*

Fund Approver Name: *BCH ID #*

Submit registration form to PrecisionVaccinesProgram@childrens.harvard.edu

Signature of *PVP* personnel approving form:	Date:

PRECISION VACCINES PROGRAM
2018-2019 ANNUAL MEMBERSHIP APPLICATION
–
COMPLETE FOR ***U.S. BASED*** MEMBERS ONLY
(If not applicable, please see non-U.S. membership form)

APPLICANT INFORMATION	
Last Name:	First Name:
Phone number:	❑ MD ❑ PhD ❑ Other _____
Institution:	
Title:	
Email address:	

MEMBERSHIP TIERS (VALID FOR 1 YEAR FROM APPROVAL DATE)		
	BASIC*	***PREMIUM*** **
Post-Doc/Trainee	❑ Free	❑ $50 USD
Academic/Government/Non-trainee	❑ Free	❑ $100 USD
Industry	❑ Free	❑ $150 USD

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BCH FUNDS	
Project ID/Fund	Bud. Ref.
BCH employees may not use federal funds to cover the cost of membership	
Fund Approver signature (above)	Date:
Fund Approver Name:	BCH ID #:

SIGNATURES	
I authorize the verification of the information provided on this form. I have received a copy of this application.	
Signature of applicant:	Date:
Signature of *PVP* personnel approving application:	Date:
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Projected 2019 Conference Registration Fees (subject to change)

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Boston Children's Hospital
4 Blackfan St. Room 837
Boston, MA 02115
Phone: 617-919-6978
Email: PrecisionVaccinesProgram@childrens.harvard.edu

Last Revised 04/22/19

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