

American Osteopathic Academy of Sports Medicine - REGISTRATION FORM

39th Annual Clinical Conference • May 1-4, 2024 • Hyatt Regency Downtown • Tulsa, Oklahoma

Please complete this registration form. Type or print legibly. One form must be filled out for each registrant and payment must accompany the registration form. Registration by telephone will not be accepted. Register by **April 1, 2024**, to take advantage of Early Registration discounts!. (Please keep a copy of this form for your records.)

Registration Information

First Name: _____
Last Name: _____
Credential(s): _____
Place of Employment: _____
Mailing Address: _____
City: _____
State/Province: _____ Zip: _____
Country: _____

Is this address: Business? Home?

Daytime Phone: _____

Email Address: _____

(Your registration confirmation will be sent via email to this address.)

Badge Information

This is how your badge will read. Please print clearly and complete only those lines that are different from the "Registration Information" above.

First Name or Nickname: _____

Full Name: _____

Place of Employment: _____

City: _____

State: _____

General Information

Please check here and list any special dietary restrictions (i.e. vegetarian, gluten free): _____

Please check if you need special assistance and an AOASM staff member will contact you shortly via email.

Check here if you wish to OPT IN to the attendee directory for the 2024 exhibitors.

Check here and list the name of the institution if you are a program director or co-director: _____

Please provide the following information in case of emergency:

Emergency Contact Name: _____

Daytime Phone: (_____) _____

Evening Phone: (_____) _____

Email: _____

AOASM Photo Release

- I acknowledge that AOASM may take photos/videos at the Clinical Conference for future marketing purposes in print or electronically.
- No, I do not give consent for my image to be used.



Registration

	On or Before 4/1/24	After 4/1/24
Member: Physician:	<input type="checkbox"/> \$550	<input type="checkbox"/> \$650
Member: Associate:	<input type="checkbox"/> \$310	<input type="checkbox"/> \$410
Member: Fellow*:	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150
Member: Resident/Intern:	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150
Member: Student:	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100
Member: Retired:	<input type="checkbox"/> \$350	<input type="checkbox"/> \$450
Non-Member: Physician:	<input type="checkbox"/> \$710	<input type="checkbox"/> \$850
Non-Member: Associate:	<input type="checkbox"/> \$460	<input type="checkbox"/> \$590
Non-Member: Fellow*:	<input type="checkbox"/> \$260	<input type="checkbox"/> \$340
Non-Member: Resident/Intern:	<input type="checkbox"/> \$260	<input type="checkbox"/> \$340
Non-Member: Student:	<input type="checkbox"/> \$200	<input type="checkbox"/> \$260
Non-Member: Retired:	<input type="checkbox"/> \$450	<input type="checkbox"/> \$570

*A Fellow is a physician currently participating in a sports medicine fellowship.

One-Day Conference Registration Fee

	On or Before 4/1/24	After 4/1/24
Physician/Associate Professionals	<input type="checkbox"/> \$300	<input type="checkbox"/> \$325
Student/Resident/Fellow	<input type="checkbox"/> \$75	<input type="checkbox"/> \$100

Which Day? Wednesday Thursday Friday Saturday

Pre-Conference Workshop Registration*

The Pre-Conference Workshops are available at a separate fee. Register on or before 4/1/2024 to receive the discounted registration fee. (*Space is limited; registration is on a first-come, first-served basis.)

Fascial Distortion Model Workshop

	On or Before 4/1/24	After 4/1/24
Member: Physician:	<input type="checkbox"/> \$495	<input type="checkbox"/> \$595
Non-Member: Physician:	<input type="checkbox"/> \$595	<input type="checkbox"/> \$695
Student/Resident/Fellow:	<input type="checkbox"/> \$295	<input type="checkbox"/> \$395

Sports Medicine Board Review Course

	On or Before 4/1/24	After 4/1/24
Member: Physician:	<input type="checkbox"/> \$849	<input type="checkbox"/> \$995
Non-Member: Physician:	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,150
Student/Resident/Fellow:	<input type="checkbox"/> \$649	<input type="checkbox"/> \$795

Continuing Education Credits

Register for continuing education credits by checking ALL applicable boxes below:

Yes, I would like to receive Continuing Medical Education (CME) credit hours and/or Board of Certification (BOC) credit hours for the Pre-Conference Workshop(s).

AOA Number: _____

BOC Number: _____

Yes, I would like to receive Continuing Medical Education (CME) credit hours and/or Board of Certification (BOC) credit hours for the annual Clinical Conference.

AOA Number: _____

BOC Number: _____

Please Note:

- You will receive a link to the credit reporting form electronically during the AOASM Conference. Attendees will be responsible for completing and submitting the form according to directions on the form.
- CME and BOC credits are NOT included in the cost of student/resident/fellow registration fees. Please contact the registrar if you'd like to add credits.

Support-a-Student

Contribution to Support-a-Student Registration Scholarship (optional)

\$100 each student X _____ # of student(s) = _____

Optional Events

Tulsa Drillers Baseball Group Outing

Thursday, May 2, 2024 – 6:30 p.m. to 10:00 p.m. CST

Number of tickets: _____ X \$40 each = _____

Student/Resident/Fellow Luncheon (no charge)*

Friday, May 3, 2024 – 12:15 p.m. - 1:30 p.m. CST

*Please sign up for this event only if you are a student/resident/fellow. Pre-registration is required to attend this event.

Award of Fellow Reception

Friday, May 3, 2024 – 6:00 p.m. to 7:30 p.m. CST

Physician/Associate/Retired/Guest:

Number of tickets: _____ X \$50 each = _____

Student/Resident/Fellow:

Number of tickets: _____ X \$30 each = _____



AMERICAN
OSTEOPATHIC
ACADEMY OF
SPORTS MEDICINE

Fees

Pre-Conference Workshop Registration Fee \$ _____

Annual Clinical Conference Registration Fee \$ _____

Support-a-Student Registration Scholarship (optional) \$ _____

Tulsa Drillers Baseball Group Outing \$ _____

Award of Fellow Reception \$ _____

Total Enclosed: \$ _____

Payment

Check a payment method and enclose your payment for registration fees, as well as any optional events in which you wish to participate.

Check (made payable in US funds, drawn on a US bank to AOASM)

Mastercard Visa American Express

Card Number: _____

Exp. Date: _____ CVV: _____

Signature: _____

Print Name: _____

Billing Address 1: _____

Billing Address 2: _____

Billing City: _____ Billing State: _____

Billing ZIP Code: _____ Billing Country: _____

Mail or fax this two-page registration form and fees to:

AOASM
2424 American Lane
Madison, WI 53704

Phone: +1-608-443-2477

Fax: +1-608-333-0310

Email: info@aoasm.org

Website: <http://www.aoasm.org>

Cancellation Policy

Any Clinical Conference registration cancellation must be made in writing directly to AOASM. If received on or before **April 1, 2024**, AOASM will apply a \$50 USD administrative fee and refund the remainder of your registration fee after the meeting. After April 1, 2024, no refunds will be given. Walk-ins and replacements are always welcome.

