

**Registration Deadline: June 10, 2024 (or when max capacity is reached)**

Completed registration forms should be emailed, faxed or mailed to the SRS office.

Email: [meetings@srs.org](mailto:meetings@srs.org) | Fax: +1 414-276-3349

Mailing Address: Scoliosis Research Society, 555 E Wells Street, Suite 1100, Milwaukee, WI, 53202, United States

**Delegate Information**

SRS ID #      First (Given) Name      Last (Family) Name      Suffix (Jr., III, etc.)      Degree (MD, PhD, etc.)

Email Address (All correspondence is done by email)      Institution

Mailing Address

City      State      Zip/Postal Code      Country (To appear on badge)

Specialty:  Orthopaedic Surgeon     Neurosurgeon    Other: \_\_\_\_\_

Assistant/Company Personnel Email Address: \_\_\_\_\_

Dietary Restrictions/Requirements: \_\_\_\_\_

Registration Instructions:

- Attendees should select either the SRS Member or Non-Member registration rate.
- Registration is limited to 30 participants. Registrations will be accepted on a first come, first-serve basis. All individuals interested in attending the course after the participant maximum has been reached will be added to a waiting list.
- Registration for the half day cervical spine add on is limited to 15 participants. Registrations will be accepted on a first come, first-serve basis. All individuals interested in attending the course after the participant maximum has been reached will be added to a waiting list.

Registration Class	Course Registration* June 10-12, 2024 (Limited to 30 participants)	Saturday, July 13: Half Day Cervical Spine Workshop (Limited to 15 participants)
SRS Member	<input type="checkbox"/> \$1,000 USD	<input type="checkbox"/> \$250 USD
Non-Member	<input type="checkbox"/> \$1,200 USD	

\*The delegate registration fee includes the Welcome Reception and "Fireside Chat" Case Discussions on Wednesday evening and lab sessions, lecture presentations, video demonstrations, breaks, and lunch on Thursday and Friday.

**Cancellation Policy:** All cancellations must be received in writing. Delegates will receive a confirmation and refund within 14 days of receipt of their cancellation notice. SRS will grant a full refund, less a 10% processing fee, for cancellations received on or before June 10, 2024. No refunds will be granted after June 10, 2024.

**Waiver:** Submission of this registration form and payment of associated fees serve as agreement by the delegate to release the Scoliosis Research Society, Centro de Treinamento Cirúrgico da Universidade Positivo and their respective agents, servants, employees, representatives, successors, and assigns from any and against all claims, demands, causes of action, damages, costs, and expenses, including attorneys' fees, for injury to person or damage to property arising from attendance at the Spine Deformity Solutions: A Hands-On Course July 2024. In addition, the delegate hereby grants permission to use his/her likeness in photographs or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration, agreeing that these materials are property of SRS which has the right to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing its programs or for any other lawful purpose. Additionally, the delegate waives any right to royalties or other compensation arising or related to the use of the photograph. **SRS Tax ID #23-7181863**

**Total Fees \$** \_\_\_\_\_

Include me on the delegate list provided to supporting companies so that they may send me information about their products, services and involvement at the course. For more information, please read our privacy policy ([www.srs.org/about-srs/contact-us/privacy-policy](http://www.srs.org/about-srs/contact-us/privacy-policy)).

**Payment Information**

Checks (US funds drawn on a US bank only) made payable to the Scoliosis Research Society or provide credit card information with complete billing address.

Check Enclosed     Visa     MasterCard     American Express

Card Number \_\_\_\_\_

Security Code \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name (As it appears on the card) \_\_\_\_\_

Billing Address \_\_\_\_\_

City      State      Zip/Postal Code

Country \_\_\_\_\_

Signature (I agree to pay according to the card issuer agreement)

