

# FOUR WAYS TO REGISTER



**CALL**  
800-217-8801



**FAX YOUR  
COMPLETED FORM  
TO 610-560-0502**



**VISIT**  
[joinIAS.com/register](http://joinIAS.com/register)



**MAIL CHECKS AND  
COMPLETED FORM\***

FIRST NAME	MIDDLE INITIAL	LAST NAME
PHONE NUMBER	EMAIL ADDRESS	
MAILING ADDRESS	CITY	STATE
ZIP CODE	COUNTRY	INSTITUTION NAME
DEPARTMENT	POSITION	

### PROFESSION:

- MD/DO
- NP/PA
- RN/Other Nurse
- Other Allied Professional
- Fellow/Resident/Student
- PharmD  RPh
- Industry/Non-clinical

### PRIMARY SPECIALTY:

- Medical Dermatology
- Cosmetic Dermatology
- Rheumatology
- Immunology
- Gastroenterology
- Psychiatry
- Other \_\_\_\_\_

### WHAT IS YOUR PRIMARY PRACTICE LOCATION?

- Urban
- Suburban
- Rural
- N/A

**NPI/LICENSE#** \_\_\_\_\_

### YEARS IN PRACTICE:

- <1 to 5
- 6 to 10
- 11 to 15
- 16 to 20
- 20+  N/A

### IN WHICH SETTINGS ARE YOU PRESENTLY EMPLOYED? (CHECK ALL THAT APPLY)

- Solo practice
- Group practice
- Medical school
- HMO
- Non-government hospital
- Government
- Other \_\_\_\_\_

### HOW MANY PATIENTS WITH AN INTERRELATED AUTOIMMUNE DISEASE DO YOU SEE ON A WEEKLY BASIS? (REQUIRED)

- 1-10
- 11-25
- 25-50
- 50+
- None

### HOW DID YOU HEAR ABOUT THE MEETING? (REQUIRED)

- I've attended past meetings
- Symposium Website
- Email/E-Newsletter
- Direct Mail/Mailed Brochure
- Google/Search engine
- Print Advertisement
- Online Advertisement
- Industry Representative
- Colleague or Friend
- Social Media
- Professional association
- IAS Sales representative
- Other \_\_\_\_\_

### WHAT WAS THE MOST INFLUENTIAL FACTOR IN YOUR DECISION TO ATTEND A LIVE MEETING? (REQUIRED)

- Educational Program
- High profile speakers
- CME/CE
- Networking
- Location
- Price
- Other \_\_\_\_\_

### DOES YOUR EMPLOYER SUBSIDIZE/ REIMBURSE FOR CME/CE MEETINGS? (REQUIRED)

- Yes at 25% or less
- Yes at 26-50%
- Yes at 51-75%
- Yes at 76-100%
- No, my employer does not subsidize/ reimburse for CME/CE meetings
- No, I am self-employed

**REFERENCE: IF YOU WERE REFERRED TO ATTEND BY A COLLEAGUE ALREADY REGISTERED FOR THIS MEETING, PLEASE REFERENCE THEIR NAME HERE:** \_\_\_\_\_

**REQUIRED FOR PHARMACISTS: NABP ID#** \_\_\_\_\_ **DATE OF BIRTH (MM/DD)** \_\_\_\_\_

**METHOD OF PAYMENT:**  VISA  MC  AMEX  DISCOVER  CHECK\*

*\*Make checks payable to HMP Communications. All checks must be drawn on a U.S. bank in U.S. funds.*

*Mail to HMP Communications, 70 E. Swedesford Rd., Suite 100, Malvern, PA 19355.*

CREDIT CARD NUMBER	EXPIRATION DATE	SECURITY CODE	
BILLING ADDRESS	CITY	STATE	ZIP

SIGNATURE OF CARDHOLDER (REQUIRED)