

**SOUTH CENTRAL ASSOCIATION FOR CLINICAL MICROBIOLOGY  
PROGRAM REGISTRATION**

*IMPORTANT: For your name badge, PRINT below, your name, affiliation, address, and telephone number.*

Name: \_\_\_\_\_ Hospital/Business: \_\_\_\_\_ Telephone: \_\_\_\_\_  Home  Work  
 Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Email: \_\_\_\_\_

STATUS	*****	PRE-REGISTRATION RATES (before March 10, 2010)		AT-DOOR REGISTRATION RATES (after March 10, 2010)	
		FULL SESSION or FRI Only	SAT. ONLY	FULL SESSION or FRI Only	SAT. ONLY
Members (a)		<input type="checkbox"/> \$90	<input type="checkbox"/> \$40	<input type="checkbox"/> \$115	<input type="checkbox"/> \$65
Non-Members (b)		<input type="checkbox"/> \$130	<input type="checkbox"/> \$80	<input type="checkbox"/> \$150	<input type="checkbox"/> \$85
Students (c)		<input type="checkbox"/> \$25	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25
Institution (d)		<input type="checkbox"/> \$100	<input type="checkbox"/> \$80	<input type="checkbox"/> \$120	<input type="checkbox"/> \$85
Additional Luncheon(e)		<input type="checkbox"/> \$30		<input type="checkbox"/> \$30	
Additional Play & Buffet (Fri Social)		<input type="checkbox"/> \$30			

**Check this box if you do not want your contact information made available to vendors.**

- (a) Register at these rates if you have a 2010 Membership Card indicating 2010 dues have been paid.
  - (b) Register at these rates if you are a non-member or have not yet paid 2010 dues. Complete the membership form on the reverse side. The fiscal year of the Association is from January 1 to December 31. This includes 2010 dues.
  - (c) Must submit evidence of student status. Does **NOT** include lunch/Fri social.
  - (d) See description of Institution pass in program. Does **NOT** include lunch/Fri social.
- Note: Unless pre-registered, there is **NO** guarantee lunch/Fri social event will be available.

Please check if vegetarian lunch is required (*pre-registered only*)

**Refer to program flyer for cancellation clause**

**Mail this form and remittance (payable to SCACM) to:**  
**South Central Association for Clinical Microbiology**  
 3735 Palomar Center Dr., Suite 150  
 Lexington, KY 40513-1147  
 888-984-9966 phone 888- 984-9966 fax  
[scacm@scacm.org](mailto:scacm@scacm.org)

\$\_\_\_\_\_ TOTAL ENCLOSED

Credit Cards **NOW** Accepted.

Credit Card Information: \_\_VISA \_\_MasterCard \_\_American Express \_\_Discover

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

Please call 888-984-9966 or email [scacm@scacm.org](mailto:scacm@scacm.org) for information. (DO NOT INCLUDE HOTEL RESERVATIONS WITH PROGRAM REGISTRATION FEE.)

**SCACM MEMBERSHIP APPLICATION AND ANNUAL FEE NOTICE**

\_\_ Annual Member \$20.00 \_\_ 3 year Membership \$45 \_\_ 5 year Membership \$75 \_\_ Life member \$200

\_\_ Sustaining Member \$200

\_\_ Contributor \$\_\_\_\_\_ Any amount. Thank you!

**Please check membership classification. This membership fee includes copies of the Newsletter, all**

**official SCACM publications, a membership card and eligible for the Mickey King travel awards.**

Please complete the following information:

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Work Telephone: ( ) Work Fax: \_\_\_\_\_ Home: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_ Preferred mailing address: ? Work ? Home

Check here if above information has been updated?

**Former Info:**

For additional information, please contact Vicky Norton, Office Manager at 888-984-9966 (voice or fax) or send an email to [scacm@scacm.org](mailto:scacm@scacm.org) Make checks payable to South Central Association for Clinical Microbiology and mail completed form to the above address. The annual SCACM membership is from January 1 to December 31.

Unless otherwise noted, membership received through the fall meetings will be credited to the current year  
We now accept credit cards.

For Credit Card Payment, please complete the following information.

American Express  Discover  MasterCard  Visa

Expiration Date: (mm/yy) \_\_\_\_\_ Amount \$ \_\_\_\_\_

**Customer Billing Information**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Company: \_\_\_\_\_

Billing address for the credit card owner:

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Country: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax: \_\_\_\_\_

Email (an email will be sent as a receipt after processing): \_\_\_\_\_

