



**Canadian Society of Respiratory Therapists**

102-1785 Alta Vista Drive, Ottawa, ON K1G 3Y6  
Tel: 1-800-267-3422 Fax: (613) 521-4314  
On-line registration at www.csrt.com

**REGISTRATION FORM  
CONFERENCE 2010**

**REGISTRANT INFORMATION**

Please print clearly

Membership Number: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please indicate your main area of practice:

- General Therapeutics/Diagnostics
- Neonatal/Pediatrics
- Critical Care
- Homecare/Community Care
- Anesthesia Assistants

**FULL CONFERENCE REGISTRATION • May 14 - 16, 2010**

**FULL REGISTRATION – REGISTER PRIOR TO APRIL 15 AND YOU WILL BE ENTERED IN A DRAW FOR A PLAYSTATION 3 (BLU-RAY)**

Includes one (1) ticket for Welcome Reception

SUBTOTAL A

Includes one (1) ticket for President’s Banquet

Will you attend the banquet?  YES  NO  Member ..... \$375  Non-Member ..... \$500 \$ \_\_\_\_\_

**STUDENT FULL REGISTRATION**

SUBTOTAL B

Includes one (1) ticket for Welcome Reception

Member ..... \$75  Non-Member ..... \$100 \$ \_\_\_\_\_

**DAILY REGISTRATION**

Please specify day:

Friday, May 14  Saturday, May 15  Sunday, May 16

SUBTOTAL C

Member ..... \$175  Non-Member ..... \$300 \$ \_\_\_\_\_

**PRE-CONFERENCE PROGRAM • Thursday, May 13 • 8 am – 4 pm**

Leadership Congress – 8:00 – 16:00

Member ..... \$100

Non-Member ..... \$200

SUBTOTAL D

Educators Congress – 8:00 – 16:30

Member ..... \$100

Non-Member ..... \$200

\$ \_\_\_\_\_

**SOCIAL EVENTS**

Welcome Reception (guest)

Thursday

\$15.00 x \_\_\_\_\_ ticket(s) = \$ \_\_\_\_\_

SUBTOTAL E

Pub Crawl

Friday

President’s Banquet (guest)

Saturday

\$75.00 x \_\_\_\_\_ ticket(s) = \$ \_\_\_\_\_

\$ \_\_\_\_\_

**PAYMENT**

Please make cheques or money orders payable to CSRT in Canadian funds

Canadian cheque  VISA  Mastercard  Canadian Money Order

SUBTOTAL (A+B+C+D+E) \$ \_\_\_\_\_

\_\_\_\_\_

Card Number

\_\_\_\_/\_\_\_\_

Expiry Date (m/y)

HST 13% \$ \_\_\_\_\_

**TOTAL** \$ \_\_\_\_\_

Cardholder’s Name \_\_\_\_\_

Cardholder’s Signature \_\_\_\_\_

**OTHER INFORMATION AND SPECIAL NEEDS**

Do not include my name in the delegate list provided to all conference participants.

Special needs (diet, accessibility, allergies, etc.): It is your responsibility to identify yourself to the server concerning dietary requirements.

50 % REFUND BEFORE MAY 7, 2010 – NO REFUND AFTER MAY 7, 2010

PLEASE SEND THIS COMPLETED FORM BY MAIL OR BY FAX ALONG WITH PAYMENT TO:  
**Canadian Society of Respiratory Therapists, 102-1785 Alta Vista Drive, Ottawa, ON K1G 3Y6**  
OR FAX TO: (613) 521-4314