# 2018 AACA Regional Meeting Registration Form
# Washington, D.C.
# October 6, 2018

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|---|---|---|---|
| Mr. ☐ Ms ☐ Mrs. ☐ Dr.☐ | First name | Middle name | Last name |
| Suffix (Jr., III ) | Degree | Institution/ Company Name | |
| Department Title/Position | Address | City | |
| State/Province | ZIP/Postal Code | Country | |
| Business Phone | Cell Phone | E-mail | |
| Do you have any dietary restrictions? If so, please indicate: | | | |

**Registration Fees**

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|---|---|
| Student/Undergraduate Registration | $30.00 _____ |
| Graduate Student Registration | $45.00_____ |
| Faculty/Clinician Registration | $100.00 _____ |

FAX forms to 706-883-8215 or postal mail to:

Mail checks to:
AACA
251 S. L. White Blvd
P.O. Box 2945
LaGrange, GA 30241

| | |
|---|---|
| Credit Card Type Visa ☐ MC ☐ American Express ☐ Discover ☐ | Amount charged to card $ |
| Card Number | Expiration Date CSC: |
| Name | |
| Billing Address (please include card zip code) | |

*For questions, contact AACA Main Office at ktyner@asginfo.net or 1-706-298-0287. Thank you for your payment!*

**Conference Photo Consent**

When you register for the AACA Regional Meeting, you affirmed that you agreed to allow AACA photographers to record your participation and reproduce your likeness in publications, online, etc.