Registration Card for SCS Pain Fellows Cadaver Lab
Wednesday, November 16th, 2011
New Orleans, LA

Boston Scientific

Full Name:____

Email:____

Street Address:____

Apt, Condo or Suite#:____

City, State and Zip:____

Cell for Travel:____

What is your specialty? Anesthesiology, PM&R, etc.

____

Are you licensed in Vermont? yes or no ____

Are you licensed in Massachusetts? yes or no____

Are you a government employee? yes or no ____

If yes, state or federal?____

What is the name of your Fellowship

Program:____

When will you finish your Fellowship?____

Where will you be going after your Fellowship?

City and State____

Name of your Boston Scientific Rep

____

I certify that the info is accurate and complete, electronic signature below

____

After fully completing this card, please email or fax this to Viktorija Telbis at viktorija.telbis@bsci.com or 818-812-7549.

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