



Forward completed registration form (one per applicant) with full payment to:
Infusion Nurses Society, 315 Norwood Park South, Norwood, MA 02062 or visit www.ins1.org to register online

Registration/Badge Information

All meeting correspondence will be sent to the address/e-mail address indicated below.

First Name _____ Name on Badge _____

Last Name _____

Credentials: RN CRNI® LPN/LVN OCN® RPh MD Other _____

Company (if applicable) _____

Address _____

City _____ State _____ Zip _____

Province _____ Country _____ Postal Code _____

Phone _____ Home Business Cell

E-mail _____

INS Membership No. _____

Are you a first-time attendee? Yes No

Emergency Contact Information

Name _____

Phone _____

Demographic Information

<p>Current Position (Select One)</p> <p><input type="checkbox"/> Clinical Nurse Specialist</p> <p><input type="checkbox"/> Consultant</p> <p><input type="checkbox"/> Director of Nursing/ Nurse Manager</p> <p><input type="checkbox"/> Educator</p> <p><input type="checkbox"/> Infusion Team</p> <p><input type="checkbox"/> Sales & Marketing</p> <p><input type="checkbox"/> Staff Nurse</p> <p><input type="checkbox"/> Other _____</p>	<p>Practice Setting (Select One)</p> <p><input type="checkbox"/> Acute Care/Hospital</p> <p><input type="checkbox"/> Academic</p> <p><input type="checkbox"/> Ambulatory/Outpatient</p> <p><input type="checkbox"/> Home Care</p> <p><input type="checkbox"/> Hospice</p> <p><input type="checkbox"/> Long-term Care</p> <p><input type="checkbox"/> Pharmacy</p> <p><input type="checkbox"/> Physician's Office/Clinic</p> <p><input type="checkbox"/> Industry</p>	<p>Area of Specialty (Select One)</p> <p><input type="checkbox"/> Admin/Management</p> <p><input type="checkbox"/> Critical Care</p> <p><input type="checkbox"/> Education</p> <p><input type="checkbox"/> Emergency Department</p> <p><input type="checkbox"/> Infection Prevention</p> <p><input type="checkbox"/> Infusion Therapy</p> <p><input type="checkbox"/> Interventional Radiology</p>	<p><input type="checkbox"/> Medical/Surgical</p> <p><input type="checkbox"/> Older Adult</p> <p><input type="checkbox"/> Oncology</p> <p><input type="checkbox"/> Pediatrics</p> <p><input type="checkbox"/> Other _____</p>
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Registration Fees

	INS Member	Nonmember
Early Bird Registration (Received by 1/15/18)	Annual Meeting (Saturday - Tuesday) Daily: <input type="checkbox"/> Sat. <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> \$595 <input type="checkbox"/> \$200/Day	<input type="checkbox"/> \$740 <input type="checkbox"/> \$285/Day
Membership Renewal	\$110 One year	\$210 Two years
	\$295 Three years	
Guest Fee (One per registrant; social events only) <input type="checkbox"/> \$150		
Guest Name _____		TOTAL ENCLOSED: \$

Registrations must be received by INS by midnight ET on discount deadline to be eligible for that rate.

Payment

Check or Money Order (DO NOT SEND CASH). Please make check or money order payable to **Infusion Nurses Society**.

Credit Card: VISA MasterCard AMEX Credit Card # _____ Exp. Date (MM/YY) _____

Cardholder name _____ Cardholder signature _____

Registration and attendance at INS meetings and events constitutes an agreement by the registrant for Infusion Nurses Society's use and distribution (both now and in the future) of the registrant's or attendee's image or voice in photographs, videotapes, electronic reproductions, or audiotapes of such meetings and events.