



FULL CONFERENCE REGISTRATION FEES
INCREASE \$30 AFTER JUNE 15, 2018

Preconference Sessions:

Pharmacologic Management July 19, 2018

- AAE Members and Military \$190
- Non-Members \$220

Conference Registration Fees

Fees include: Friday breakfast, lunch and reception, Saturday breakfast and lunch, Sunday breakfast, daily morning and afternoon breaks. July 20-22 2018

- AAE Members** – \$360 for Conference
- Non-Members** – \$460 for Conference

Conference Special Rates:

- Special rate- New Members:**
Join AAE for \$80.00 and pay the Member Fee for the complete conference (\$360) for a total of \$440 (a \$20.00 savings)
- Military:** We honor those who serve: Pay the Member Rate of \$360 and obtain a free one year membership. Please include a photo copy of your military ID with registration.

Student Rates:

- Student Poster Presenters: Complimentary registration if with a mentor paying the full rate.
- Student rate – \$165.00 Early Rate!

Conference Single Day Rates:

- Friday \$190
- Saturday \$190
- Sunday \$120
- Friday/Saturday Rate \$275
- Saturday/Sunday \$245

- Yes! I am interested in volunteering to assist with the AAE's Community Service Project on July 19, 2018
- I am a first time attendee
- Special Meal options requested
- Food allergies (list below)

AAE Conference Registration

20th Anniversary July 20-22, 2018

AAE Mission Statement

The Association of Asthma Educators is the premier inter-professional organization striving for excellence to raise the competency of diverse individuals who educate patients and families living with asthma.

Mail or fax form to:

Association of Asthma Educators,
 70 Buckwalter Road Ste 900 # 330, Royersford, PA 19468. Phone: 610-772-0661 Fax: 215-361-9920 [ONLINE REGISTRATION](#): Email: admin@asthmaeducators.org

Attendee Information

Name _____

Credentials _____ Unique Identifier (Last 4 digits SSN#, license #, AARC#) _____

Current Title/Position _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Method of Payment

Authorized Signature _____ Print Name _____ Date _____

Total Amount _____

- Check Mastercard VISA AMEX Discover

Card Number _____ Expiration Date _____ Security Code _____

Name of Card Holder (Print) _____ Signature _____

Billing Address (if different from above) _____