Registration Form

2027 KPMA Annual Scientific Meeting

Please print

Doctor registration includes *admission to lectures and exhibit hall, & breakfast, and lunch each day.*

Dr. Name _____ **Practice Name** _____

Email _____ **Phone** _____

Address _____ **City, State, Zip** _____

I am a member of the_____*(state abbr.)* **Podiatric Medical Association.**

REGISTRANT TYPE	**Badge Name** *(First and Last)*	***Thru 3/26*** **Regis Fee**	***After 3/26*** **Regis Fee**	**SUBTOTAL**
KPMA Member Doctor		**$350**	**$500**	
Out-of-State APMA Member Doctor		**$400**	**$550**	
Resident/ Student		**$75**	**$75**	
Non-Member Doctor		**$650**	**$800**	

TOTAL: $_____

☐ **Check #**_____**enclosed** *(payable to KY Podiatric Medical Association)*

☐ **Charge my** *(circle one)* Visa MC AMEX Discover

Credit Card #_____**Exp**_____**Sec Code** _____

Name on card_____**Email for receipt** _____

Billing Address _____

City_____**State**_____**Zip** _____

Return this completed form *with payment* by mail (KPMA, 5932 Timber Ridge Drive, Ste 101, Prospect, KY 40059) or email (michelle@kypma.org).

Questions? michelle@kypma.org or 502-223-5322.