

Register for the Clinical Conferences

Use this form to register by mail or fax
or register online at www.thebowencenter.org

Name: _____

Please write your name and academic credentials as you would like them to appear on your name tag.

Organization: _____

Address: _____

Daytime phone: _____

E-mail: _____

Credit card: Visa Mastercard Discover
(check one)

Credit Card #: _____

Expiration date: _____

Signature: _____

Clinical Conference Fees

Please circle your choices:

Entire Series

| | | |
|----------------------|----------|----------|
| Regular | \$845.00 | save 30% |
| Bowen Center Trainee | \$660.00 | save 35% |
| Full-Time Student | \$240.00 | |

Four Conference Package

| | | |
|----------------------|----------|----------|
| Regular | \$400.00 | save 25% |
| Bowen Center Trainee | \$320.00 | save 30% |
| Full-Time Student | \$100.00 | |

Dates Selected : 1) _____ 2) _____
3) _____ 4) _____

Individual Conference

| | |
|----------------------|----------|
| Regular | \$135.00 |
| Bowen Center Trainee | \$115.00 |
| Full-Time Student | \$40.00 |

Date Selected : 1) _____

CEU Fee:

Number of Conferences x \$15 = _____

TOTAL: _____

Please make check payable to The Bowen Center.
Outside the US, use a certified check or credit card.

Mail or fax this form with your payment to:

The Bowen Center
4400 MacArthur Boulevard, NW Suite 103
Washington, DC 20007-2521
Phone: 202-965-4400 Fax: 202-965-1765