 TEAM REGISTRATION FORM

- This is a 2-page form and cannot be processed without 2 pages per team
- No refunds will be given for cancellations after February 1, 2013.
- Fax or email completed form to Rachel Smiroldo at rachel@aapm.org or 301-209-0862

Team Registration: Team registration consists of a 3-person team from a single practice. Teams must be composed of a Physicist and/or Oncologist and/or Therapist and/or Dosimetrist and/or Administrator from your practice. (i.e. no more than one of each). Each registration includes continental breakfast and lunch on Friday and Saturday.

<table>
<thead>
<tr>
<th>Team Registration</th>
<th>Payment Policy: If you have registered and are paying by check, your payment must be RECEIVED no later than January 9, 2013 to receive the early registration fees. ALL PAYMENTS MUST BE RECEIVED BY FEBRUARY 1, 2013.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three member team</td>
<td>$900</td>
</tr>
</tbody>
</table>

Team Registration saves you $$: Individual registration = $375/ early member and $475/early nonmember

TEAM MEMBER #1 Registration Information

Name: ___________________________ Badge Name (first name only): ___________________________
Title: ___________________________ Degree: ___________________________
Company/Organization: _________________________________________________________________
Department: ___________________________
Mailing Address 1: _________________________________________________________________
Mailing Address 2: _________________________________________________________________
City: ___________________________ State: ___________________________ Postal Code: __________
Country: ___________________________
Phone: ___________________________ Fax: _____________________________________________
EMail Address (must be included to receive confirmation): ________________________________

Please indicate your area of specialization (you must check one of the below for your registration to be complete):

□ Physicist □ Oncologist □ Therapist □ Dosimetrist □ Administrator

TEAM MEMBER #2 Registration Information

Name: ___________________________ Badge Name (first name only): ___________________________
Title: ___________________________ Degree: ___________________________
Please indicate your area of specialization (you must check one of the below for your registration to be complete):

□ Physicist □ Oncologist □ Therapist □ Dosimetrist □ Administrator

Phone: ___________________________ Fax: _____________________________________________
EMail Address (must be included to receive confirmation): ________________________________

□ Check here if you have the same company and address information as the Team Member #1, otherwise please complete the section below.

Company/Organization: ______________________________________________________________
Department: ___________________________
Mailing Address 1: _________________________________________________________________
Mailing Address 2: _________________________________________________________________
City: ___________________________ State: ___________________________ Postal Code: __________
Country: ___________________________
TEAM MEMBER #3 Registration Information

Name: ____________________________________________ Badge Name (first name only): ________________________________
Title: ____________________________________________ Degree: ____________________________________________

Please indicate your area of specialization (you must check one of the below for your registration to be complete):

□ Physicist □ Oncologist □ Therapist □ Dosimetrist □ Administrator

Phone: ________________________ Fax: __________________________

EMAIL Address (must be included to receive confirmation): ____________________________________________________

□ Check here if you have the same company and address information as the Team Member #1, otherwise please complete the section below.

Company/Organization: ____________________________________________________________
Department: _________________________________________________________________
Mailing Address 1: _____________________________________________________________
Mailing Address 2: _____________________________________________________________
City: __________________________ State: ____________________ Postal Code: _________________
Country: _______________________________________________________________________

REGISTRATION TOTAL: $900

Please answer the following mandatory questions (Answering these questions will help the program organizers provide you with a better program):

1) The status of my institutions accreditation is:
   a. Full Accredited
   b. Application has been submitted
   c. Currently completing the application in preparation to submit
   d. Still thinking about accreditation

2) If you have not yet submitted your application, when do you intend to apply?
   a. In the next 6 months
   b. 6 months - 1 year from now
   c. 1 year or more from now

3) How familiar are you with the accreditation process?
   a. Very familiar, a veteran of the accreditation process
   b. Somewhat familiar
   c. Not familiar at all

If you would like for an invoice to be prepared for this team registration, please complete the section below and either fax or email this to:

AAPM ROPA Team Registration
Attention: Rachel
Fax: 301-209-0862
Email: Rachel@aapm.org

Invoice should be mailed to (please provide Team contact):
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Full payment MUST BE submitted by February 1, 2013 (per instructions provided on invoice).
Please Call AAPM with any questions: 301-209-3371 or email rachel@aapm.org