



SCHOOL OF MEDICINE



EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

Making the Rounds Medical Alumni Weekend 2010

Please register by Friday, September 17th.

Add an additional \$20 late fee should be included for all registrations postmarked after Friday, September 17th.

Cancellations must be made by Friday, September 17th to receive a refund.

Return in the enclosed envelope or mail to:

Office of Development and Alumni Relations
1440 Clifton Road, NE Suite 170
Atlanta, GA 30322

Last Name: _____ First Name: _____

Medical School Class Year: _____

For resident and fellow alumni, year training was completed and program: _____

E-mail: _____

Guest Name(s) and ages, if children; class year, if alumni

Guest #1: _____

Guest #2: _____

Guest #3: _____

Preferred Mailing Address Home Business

Home Address: _____

City: _____ State: _____ ZIP: _____

Business Name: _____

Business Address: _____

City: _____ State _____ ZIP: _____

Phone Numbers: (home) _____ (work) _____

Please complete reverse side of registration form.

Name: _____ Class Year: _____

Please indicate number attending

Friday, September 24

Events	Number	Cost/Person	Total
Medical Alumni Association Dinner		\$40	\$

Saturday, September 25

Events	Number	Cost/Person	Total
Medical History Symposium – CME Credit		\$25	\$
Medical History Symposium – No CME Credit		No Charge	N/A
School of Medicine Building Tour		No Charge	N/A
Shuttle Tour of Emory Campus		No Charge	N/A
Golden Caduceus Society Luncheon		\$35	\$
BBQ & Bluegrass – Adults		\$20	\$
BBQ & Bluegrass – Children 4-11		\$8	\$
BBQ & Bluegrass – Children 3 & under		No Charge	N/A
Class of 1960 ~ 50th Reunion Luncheon		\$35	
Grady Hospital Tour – 2 p.m. departure		No Charge	N/A
Hurst Residency Program Reunion		No Charge	N/A
Class of _____ Reunion (specify class year)		\$95	\$
Class of 1960 – 50th Reunion Dinner		\$100	\$

Total Registration Fees	\$
Late fee for registrations postmarked after September 17th (\$20)	\$
Reunion Gift: I would like to add a tax-deductible reunion gift to support teaching and learning at the School of Medicine. Please direct my gift to: <input type="checkbox"/> School of Medicine Scholarship Fund <input type="checkbox"/> Departmental residency fund _____ <i>(please specify department)</i>	\$
Total Amount Enclosed	\$

I request: _____ vegetarian meal(s) for the events for which I have registered.
(no. needed)

Please let us know if you have any special needs: _____

Payment Information

Check payable to Emory University
 MasterCard Visa American Express
 Card Number: _____ Exp. Date: _____
 Name on Card: _____ Security Code: _____
 Signature: _____ Date: _____

Billing address, if different than mailing address:

Billing Address: _____ City: _____ State: _____ ZIP: _____