



DIAMOND HEADACHE CLINIC  
RESEARCH & EDUCATIONAL  
FOUNDATION

**EARLY BIRD DISCOUNTED RATES  
FOR REGISTRATIONS RECEIVED BY  
OCTOBER 31, 2017.**

**FAX FORM TO: (312) 867-9109**

**EMAIL FORM TO: [jdeleon@diamondheadache.com](mailto:jdeleon@diamondheadache.com)**

**The 31st Annual Practicing Physician's Approach  
to the Difficult Headache Patient  
February 16-19, 2018**

**Omni La Costa Resort & Spa  
Carlsbad, CA (San Diego Area)**

**Discounted room rate based on availability until 1/12/18.  
Room rates are only available to registered meeting attendees.**

**MEETING ATTENDEE INFORMATION: (please print clearly)**

First Name		Last Name		Middle Initial
Degree (please check one) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PhD <input type="checkbox"/> PsyD <input type="checkbox"/> DDS <input type="checkbox"/> Pharma Industry <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> RN <input type="checkbox"/> RPh <input type="checkbox"/> PharmD <input type="checkbox"/> Other Health Professional			Specialty	
If mailing to an office please include the Name of the Institution/Hospital				
Street Address, please include Suite # or Floor				
City	State/Province	Country	Zip	
Business Phone		Business Fax		
Cell Phone (for emergency purposes)		Attendee Email Address – will receive the link for course syllabus		

**REGISTER BY OCTOBER 31, 2017 TO RECEIVE DISCOUNTED REGISTRATION FEE**

**REGISTRATION FEE: (please check one)**

**PAYMENT TYPE: (please check one)**

<input type="checkbox"/> \$400 (MD/DO/PhD/PsyD/DDS/Pharma Industry) – 4 DAYS	<input type="checkbox"/> Check Payment Enclosed
<input type="checkbox"/> \$300 (PA/NP/RN/RPh/PharmD/Other Health Prof.) – 4 DAYS	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Amex <input type="checkbox"/> Discover
<input type="checkbox"/> \$50 - Flash Drive with Syllabus Electronic Book The hyperlink to download and/or print the PDF of the course syllabus will be emailed 3-5 days prior to conference. Please provide the email address to use for the delivery of this hyperlink.	<b>Total Amount To Be Processed: \$_____.</b>

**CREDIT CARD/CARD OWNER INFORMATION: (please print clearly)**

Credit Card Number		Expiration Date	CVV Number(3 or 4 digit code)	
Card Owner First Name	Card Owner Last Name	Middle Initial	Telephone Number	
Credit Card Billing Address		Business Name on Credit Card		
City	State/Province	Country	Zip	
Email Address of the person to get transaction receipt.				