

## Registration Information

### BEFORE, OR ON, August 31st:

Individual (# of Individuals): \_\_\_\_\_ X \$15.00 = \_\_\_\_\_  
Family (3-5 Individuals): \_\_\_\_\_ X \$35.00 = \_\_\_\_\_  
Number of Patients: \_\_\_\_\_ X FREE = 0  
Total = \_\_\_\_\_

### AFTER August 31st:

Individual (# of Individuals): \_\_\_\_\_ X \$25.00 = \_\_\_\_\_  
Family (3-5 Individuals): \_\_\_\_\_ X \$55.00 = \_\_\_\_\_  
Number of Patients: \_\_\_\_\_ X FREE = 0  
Total = \_\_\_\_\_

**\*\*\*All patients are free\*\*\***

**\*\*\*Children under 3 years-old are free\*\*\***

## Payment Information

**Please make checks or money orders payable to the:**

“Thalassemia Support Foundation”

**Mail to:**

Thalassemia Support Foundation

PO Box 26398

Santa Ana, CA 92799

**\*\*\*Please complete other side\*\*\***

## Registration Information

### BEFORE, OR ON, August 31st:

Individual (# of Individuals): \_\_\_\_\_ X \$15.00 = \_\_\_\_\_  
Family (3-5 Individuals): \_\_\_\_\_ X \$35.00 = \_\_\_\_\_  
Number of Patients: \_\_\_\_\_ X FREE = 0  
Total = \_\_\_\_\_

### AFTER August 31st:

Individual (# of Individuals): \_\_\_\_\_ X \$25.00 = \_\_\_\_\_  
Family (3-5 Individuals): \_\_\_\_\_ X \$50.00 = \_\_\_\_\_  
Number of Patients: \_\_\_\_\_ X FREE = 0  
Total = \_\_\_\_\_

**\*\*\*All patients are free\*\*\***

**\*\*\*Children under 3 years-old are free\*\*\***

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## Mail-in Registration Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Please list the name and age (if under 18) of ALL conference attendees

Place a check in the box if the attendee is a patient

Check box if Patient	Name	Age (if under 18)
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

\*\*\*Please complete other side\*\*\*

## Mail-in Registration Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Please list the name and age (if under 18) of ALL conference attendees

Place a check in the box if the attendee is a patient

Check box if Patient	Name	Age (if under 18)
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

\*\*\*Please complete other side\*\*\*