2020 Hands on Cadaver Workshop Registration Form

This registration form does not confirm the requested time and date of the workshop.
A confirmation email will be sent out to the requesting party regarding the confirmation and details of the workshop request.

Name: ______________________ ☐ MD ☐ DO ☐ Other ______________
As you would like seen on your certificate

Specialty: ______________________

Mailing Address: ______________________

City: ______________ State: ________ Zip: ______ Country: ______________

Phone: ______________ Fax: ______________

Email: ______________________

How did you learn about this workshop? ______________________

☐ Internet ☐ Tradeshow: ______________________

☐ Email ☐ Sales Representative - Rep Name: ______________________

elliquence Educational Institute

at elliquence Headquarters • 2455 Grand Avenue, Baldwin, New York

Requested Dates and Times **(Please give 2-3 dates and times you would like to be trained)**

______________ ______________ ______________

Requested Topic of Training **(Please select your top 2)**

☐ Endoscopic Transforaminal ☐ Endoscopic Rhizotomy ☐ Lumbar Discectomies with Disc-FX

☐ Endoscopic Interlaminar ☐ Endoscopic Stenosis ☐ Cervical Discectomies with Disc-FX Mini

Please feel free to bring in MRI's of upcoming surgical candidates to the workshop to discuss.

Please charge registration fee to my: ☐ Visa ☐ Mastercard ☐ AmEx ☐ Wire Transfer

Card #: ______________________

Exp: ______________ Security Code: ______________

Cardholder's Name: ______________________

Cardholder's Address (if different the participant) ______________________

If you cancel 7 days or less from the confirmed date, we will charge you a cancelation fee of $250.

Please email completed registration form to **labs@elliquence.com**

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