elliquence
Less Is More®

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: _____

Mobile Phone: _____ Work Phone: _____

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)**

☐ Lumbar Discectomies with Disc-FX

☐ Cervical Discectomies with Disc-FX Mini
(for Experienced Disc-FX Lumbar Users)

☐ Endoscopic Rhizotomy

☐ Endoscopic Interlaminar
(for Experienced Endoscopic Users)

☐ Endoscopic Transforaminal

☐ Endoscopic Stenosis
(for Experienced Endoscopic Users)

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

There is no charge for attending the event. However there is a $250 cancellation fee if you cancel withing 7 days or less of the event.

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) _____

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

elliquence Educational Institute
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Phone: 516-277-9000 • www.elliquence.com

MUST COMPLETE PAGE 2 →

Physician Practice Metrics

Physician's Name: _____ Specialty: _____

Practice Locations Name and Address			
Phone			
Facility's Contact Name:			
Facilities you anticipate to operate in:			
Policies for bringing in new products:			
Credential requirements to start a new procedure from your facility			
Contacts and phone numbers at the Facility for beginning the process:			
Rep Credentialing Organization:			

elliquence Reps's name? _____

CHECK ALL THAT APPLY

Insurances and Payment ☐ Major Med's ☐ Medicare ☐ Personal Injury ☐ Cash Pay

If personal injury was selected, what is your practice percentage? ☐ Less than 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

If cash was selected, what percentage of your practice is cash? ☐ Less than 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Procedural Experience & Volume	Yes (#) of cases /month	No	Anticipated Volume After Training. Cases Per Month ↓ PLEASE FILL IN
Injections			
Discograms			
Intradiscal Therapies (Thermal, Mechanical)			
Disc-FX			
Disc-FX Mini			
Transforaminal Endoscopy			
Interlaminar Endoscopy			
Endoscopic Rhizotomy			
Microscopic Tubular Surgery			
MIS Fusion			
Others (ie:)			

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