

2009 Port Wine Stain and Vascular Birthmarks Conference  
sponsored by  
**the Vascular Birthmarks Foundation and  
the Beckman Laser Institute and Medical Clinic**  
Friday and Saturday, October 9-10, 2009  
Island Hotel, Newport Beach, California

**Conference/Clinic Registration Form**

Register now. Early registration ensures *free lodging for Friday night (one room per family)* and a discounted second night hotel room (you only pay \$108.09 if you opt for the second night). Light food is also included for Friday evening, and breakfast & lunch is included for Saturday.

PLEASE MAKE YOUR RESERVATION BEFORE August 1, 2009 TO ENSURE THE FREE ROOM FOR FRIDAY AND/OR REDUCED RATE FOR SATURDAY. We cannot guarantee these same savings after the deadline and cannot guarantee any rooms after the 50 reserved rooms are filled.

**\*To make your hotel reservation, contact VBF Executive Assistant, Basia Joyce at: [basiajim99@nycap.rr.com](mailto:basiajim99@nycap.rr.com), or by phone: Home: 518-374-2062, or Cell: 518-495-3938. Conference physicians, speakers and presenters can secure a room by contacting The Island Hotel directly, or you may also contact Basia Joyce for assistance. (See contact information for the hotel in "Section 2 – Lodging and Meals".)**

A CREDIT CARD NUMBER IS REQUIRED TO RESERVE A HOTEL ROOM, EVEN IF THE ROOM PROVIDED IS COMPLIMENTARY.

Also, \$25.00 deposit is required to hold your space. The conference and clinic appointment fees are \$50.00 each per registration. The \$25.00 deposit will be applied toward your conference fee (\$50) and/or your clinic fee (\$50). All fees are due by September 15, 2009. See Section seven for details and for waiver of fees details.

**NOTE: Mail this completed registration form to VBF at PO Box 106, Latham, NY 12110 with a photo; or you can email it to Basia Joyce at [BasiaJim99@nycap.rr.com](mailto:BasiaJim99@nycap.rr.com) with one JPEG of the birthmark; or you can register on-line using a credit card and attach a JPEG photo of the birthmark.**

**Section 1 – Family/Patient Contact Information**

Please indicate with a mark what you are requesting: \_\_\_\_\_ conference at \$50.00 \_\_\_\_\_ clinic at \$50.00.

Name(s) of patient: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Name(s) of patient: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Names of Parent or Guardian if patient is a child: \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (How can we best reach you?)

(home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Email: \_\_\_\_\_

Name of Patient's  
Physician \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please include names and ages of siblings, family members or friends who will be joining you and the patient at the conference. For adults, please mark *adult* where it requests age.

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Physician Attending Conference Information - Fee is \$100 for physicians attending the conference who are not speaking or participating on clinic teams or breakout sessions.**

Physician Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (How can we best reach you?)

(home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

(email) \_\_\_\_\_

Please include names and ages of family members, friends or associates who will be joining you. For adults, please mark *adult* where it requests age.

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Physician \_\_\_\_\_

**Volunteer/Speaker/Special Session Provider or Clinic Team Participant Information (This includes volunteers, attending nurses, sponsors and those providing conference services, etc)**

Name \_\_\_\_\_ Describe your role \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (How can we best reach you?)

(home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

(email) \_\_\_\_\_

Please include names and ages of siblings, family members or friends who will be joining you. For adults, please mark *adult* where it requests age.

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

## Section 2 – Lodging and Meals

Free rooms are being held for the first 50 registrants at The Island Hotel located at 690 Newport Center Drive, Newport Beach, CA 92660 – Website: [www.theislandhotel.com](http://www.theislandhotel.com), Toll Free: 866-554-4620

\*For more information on hotel accommodations, see page one of this registration form.

Friday night reception includes hors d'oeuvres and beverages. On Saturday, there will be a continental breakfast and lunch provided for you. These meals are provided by BLI at no cost to you.

Will you be attending the Friday welcome reception, which will begin at 5pm on Friday \_\_\_ Yes \_\_\_ No  
# of adults \_\_\_\_\_ aged 13 and up # of children \_\_\_\_\_ 13 and under. Vegetarian \_\_\_\_\_

Will you be attending the continental breakfast on Saturday morning \_\_\_ Yes \_\_\_ No.  
# of adults \_\_\_\_\_ aged 13 and up # of children \_\_\_\_\_ 13 and under. Vegetarian \_\_\_\_\_

Will you have lunch on Saturday \_\_\_ Yes \_\_\_ No.  
# of adults \_\_\_\_\_ aged 13 and up # of children \_\_\_\_\_ 13 and under. Vegetarian \_\_\_\_\_

## Section 3 – Friday Night Breakout Sessions

On Friday night, following the welcome reception, there will be informal **breakout sessions** from 9:00 pm to 10:00pm with physicians and medical experts answering your questions. Indicated below are the topics. Check the session that you would like to attend and indicate the number of people attending in your party. This will be a great chance for you to meet informally with medical experts to ask questions about your vascular birthmark and/or related syndrome.

*Note: Physicians, please indicate if you would like to be on one of the teams for a breakout session.  
Families, please indicate if you would like to attend a Friday night break out session.*

1. Hemangioma \_\_\_\_\_ attending.
2. Malformations \_\_\_\_\_ attending.
3. Port Wine Stain \_\_\_\_\_ attending.
4. Syndromes (KTS, SWS, CMTC, PHACE) \_\_\_\_\_ attending.

## Section 4 - Clinic Registration/Information

Clinic appointments will be on Saturday, October 10, from 1pm-6pm. BLI will provide free shuttle transportation to and from BLI for the clinic appointments.

If you would like a clinic appointment, please complete the following:

\_\_\_ Yes, I would like a clinic appointment. If possible, I would like an appointment at: \_\_\_\_\_ (approximate time). Clinic appointments will begin at 1pm with the last one scheduled to begin at 5:30 pm. There will be 4 clinic teams that are listed below. Clinic appointments last about 15 minutes.

For those of you with travel constraints, please write below what time you need to be seen by in order to give you time to get to the airport or make other travel requirements: \_\_\_\_\_

Please mark information below regarding clinic team.

**Physicians: Please indicate the team on which you would like to work.**

**Families: Please indicate which team you would like to be seen by.**

**Note: If you request a clinic appointment, please include a photo of the patient clearly showing the birthmark with this registration form. If you have any films, MRIs, Xrays or Scans, please bring them to the clinic appointment, along with photos that document the history of the birthmark. **We will contact you prior to the conference regarding this information.** Do not mail imaging studies to VBF.**

**Clinic Teams: Place X next to team**

- 1. Hemangiomas \_\_\_\_\_
- 2. Malformations (AVMs, Venous, Lymphatic) \_\_\_\_\_
- 3. Port Wine Stains \_\_\_\_\_
- 4. Syndromes (KTS, SWS, CMTC, PHACE) \_\_\_\_\_

If you are unsure of your team preference, but would like to see a particular physician, please write his or her name below:

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Do you or anyone coming to the conference require special needs? This includes travel schedule constraints or health concerns or disabilities that require attention.

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Briefly describe the birthmark. Include location and any treatment(s) to date.

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### **Section 5 - Daycare Services**

Daycare services will be provided free of charge. Will you need daycare services? \_\_Yes \_\_ No. Age(s) of child(ren) that will need the services: 1<sup>st</sup> child age: \_\_\_\_\_ 2<sup>nd</sup> child age: \_\_\_\_\_ 3<sup>rd</sup> child age: \_\_\_\_\_ 4<sup>th</sup> child age: \_\_\_\_\_

### **Section 6 - Make-up, Patient & Family Discussion Sessions and/or Billing and Insurance Sessions**

Please indicate the number attending each session on the line after the session description and the number of people attending. Make-up Session: \_\_\_ (yes or no) # \_\_\_\_\_ Patient and Family Discussion Sessions: \_\_\_ (yes or no) # \_\_\_\_\_ Billing and Insurance Session \_\_\_ (yes or no) # \_\_\_\_\_ If you require more information on these, please contact Basia Joyce, VBF Ex. Asst. at Home – 518 374-2062, Cell – 518- 495-3938 or by email at: [BasiaJim99@nycap.rr.com](mailto:BasiaJim99@nycap.rr.com)

## Section 7 - Registration Fees

**Registration Fee** is \$50.00 per family for the conference and \$50.00 per family for the clinic. \$100 for conference and clinic per family. **A non-refundable \$25 minimum deposit is required by September 15, 2009.** Balance is due prior to the conference. Send check, money order or provide credit card information.

Credit card type:  M/C  Visa  Discovery

Credit card number: \_\_\_\_\_ Date of Expiration \_\_\_\_\_

Name as it appears on credit card \_\_\_\_\_ Amount: \_\_\_\_\_

*Note: All credit card transactions require full payment of \$50 clinic, \$50 conference or \$100 for both with this registration. \$25 deposit is non-refundable. If you are unable to pay the clinic and/or conference fees due to financial hardship, check and sign below. Those fees will be waived; however, the \$25.00 deposit is still required even if fees are waived due to hardship.*

### Hardship Waiver:

Please check here if you cannot afford to pay the balance of the clinic or conference fees and sign your name

(I request waiver of the remaining fee) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Section 8 Refund Policy

\$25 deposit fee is non-refundable. Any balances paid in addition to the \$25 deposit will be refunded to anyone who cancels his or her registration by October 1, 2007. There will be no refunds for anyone who cancels after that date.

Amount enclosed: \$\_\_\_\_\_. Thank You. You will receive a confirmation of your registration. Please keep the confirmation letter for admission to the conference.

Please send registration form and fee to Vascular Birthmarks Foundation, P.O. Box 106, Latham, NY 12210 as soon as possible. For more information or if you have any questions, contact Basia Joyce, VBF Ex. Asst. at Home: 518-374-2062, Cell: 518-495-3938, or by email at: [BasiaJim99@nycap.rr.com](mailto:BasiaJim99@nycap.rr.com)

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**NOTE: PLEASE MAKE A COPY FOR YOUR RECORDS**