2018 CONFERENCE & CLINIC REGISTRATION

NAME AND ADDRESS OF PRIMARY CONTACT

All questions and conference correspondence will be directed to the individual listed immediately below; please identify an adult over the age of 18.

First Name* ______________________________

Last Name* ______________________________

Street Address* ______________________________

City* ______________________________

State* ______________________________

Postal Code* ______________________________

Country* ______________________________

Phone * ______________________________

Email * ______________________________

CONFERENCE FEES

The $100 per patient conference registration fee includes all conference and special sessions, clinic appointments (if available), breakfast and lunch for the patient and accompanying persons, daycare (if needed), and one night of lodging for those who qualify and are deemed eligible. Those who request a waiver for financial hardship will be required to pay a $25 processing fee.

____________________ I/We agree to pay the $100 conference registration fee.

____________________ I/We request a fee waiver for financial hardship and agree to pay the $25 processing fee only.

VENUE DETAILS

Incidentals will be charged by the hotel to the guest credit card on file. Guests must provide the hotel with a personal credit card for incidental charges upon check in. Any hotel guests who do not attend the conference and neglect to cancel within the normal cancellation window, or who stays in a hotel room but does not attend the conference, will be charged by the hotel for the full rate of the room, tax and any related charges.

_________________ I/We would like to be considered for a free hotel room and agree to the terms above.

All fields marked with an asterisk (*) are required.

PAYMENT INFORMATION

❑ Check enclosed for the conference fee of $100 (payable to: Vascular Birthmarks Foundation)

❑ Check enclosed for the conference fee of $100 minus $75 for financial hardship (payable to: Vascular Birthmarks Foundation). You must fill out the waiver part of this application or your application will not be processed.

❑ Charge my credit card

❍ Visa ❍ MasterCard ❍ Discover ❍ American Express

Name on Card ____

Card Number ____

Expiration __________ Security Code __________ Billing Zip Code __________

Signature ____

❑ I would like to add an additional contribution in the amount of: _________________________________

All additional contributions will be used to sponsor another family to attend the conference.

Please do NOT email this form to anyone. Even as attachment, your information is not confidential. This form is for use with postal mail only.

SECTION 1: Patient Details

First Name* ____

Last Name* ____

Gender* ❑ Male ❑ Female

Age ___________ For patients under age 13, is daycare required? ❑ Yes ❑ No

Dietary restrictions ____

Photography consent ❑ Yes ❑ No
Yes indicates consent for VBF to use patient's image in future conference materials or on any VBF-owned website.

Visa letter ❑ Yes ❑ No
For out-of-country registrants, is a letter of invitation required for your embassy to issue a visa to the U.S.?

All fields marked with an asterisk (*) are required.

SECTION 2: Patient Medical Background

Physician Name ____

Practice Name ____

Practice Address ____

Physician E-mail ____

Physician Phone ____

Practice Website ____

Birthmark Location ____

Birthmark Type

❑ Hemangioma ❑ Port Wine Stain ❑ Venous Malformation

❑ AVM ❑ Lymphatic Malformation ❑ Combination

❑ Other ______________________________ ❑ Unknown / Not Sure

Birthmark-related Syndrome

❑ Sturge-Weber ❑ Klippel-Trenaunay ❑ PHACE Syndrome

❑ Other ___________________________ ❑ Unknown / Not Sure

Photograph Enclosed ❑ Yes ❑ No

Return this application with a clear photograph of the patient's birthmark or syndrome; if internal, substitute a clear photo of the patient. A photo of the patient's vascular birthmark or birthmark-related syndrome is required to complete this registration. Those who do not provide a photo will not be eligible to be considered for clinical appointments, laser treatment, dental exams, or to be considered for a free hotel room.

SECTION 3: Clinic Appointments

REMINDER: Clinic and Special Sessions appointments are scheduled for ***patients*** *only. Choose the team(s) that best apply to patient's condition.*

Requested Clinic Appointment(s):

- ❑ Team 1 – Hemangiomas and PWS Requiring Surgery
- ❑ Team 2 – Malformations of the Head & Neck
- ❑ Team 3 – Extremity & Internal Malformations
- ❑ Team 4 – Port Wine Stains -Adults
- ❑ Team 5 – Port Wine Stains – Infants and Children
- ❑ Team 6 – Sturge-Weber syndrome and PHACE syndrome
- ❑ Team 7 – Klippel-Trenaunay syndrome

SECTION 4: Special Sessions

Choose the appointment(s) that the patient would like to attend:

- ❑ Insurance
- ❑ Make-Up (patient only)
- ❑ Orthodontal Exam (patient only)

FAMILY SUPPORT AND PSYCHOTHERAPY GROUP SESSIONS

- ❑ For Parents of Children 10 and under with a vascular birthmark
- ❑ For Tweens to Teens and Young Adults (11 to 20) living with a vascular birthmark
- ❑ For Adults (21 and over) living with a vascular birthmark

If confirmed, would patient like to be considered for either of these tentatively scheduled sessions?

Dental and orthodontic exams will be subject to qualification and availability. Note that dental and orthodontic exams, if offered, will be held on ***Friday, October 5****, on the day before the Conference at an off-site location in New York, New York. If you are eligible, we will contact you with further information about offerings and instructions as the examination schedule is finalized.*

❑ Yes ❑ No Dental Exam

❑ Yes ❑ No Laser Treatment (must meet criteria)

Requested time for clinic appointment:

- ❑ No preference
- ❑ 1:00 – 2:00 pm
- ❑ 2:00 – 3:00 pm
- ❑ 3:00 – 4:00 pm
- ❑ 4:00 – 5:00 pm
- ❑ 5:00 – 6:00 pm

All afternoon appointments will be assigned to avoid time conflicts if possible. Please let us know of any additional time conflicts due to travel (e.g., early flights) or other obligations (e.g. infant nap times, etc).

Schedule Conflicts ______________________________

All fields marked with an asterisk (*) are required.

SECTION 5: Accompanying People

Please identify every attending person in your party. Registrations are limited to four people, including the patient.

ACCOMPANYING PERSON #1

First Name* ____

Last Name* ____

Relationship to patient ❑ Mother ❑ Father ❑ Grandparent ❑ Sibling ❑ Guardian ❑ Other/Friend

Under Age 13 ❑ Yes ❑ No Indicate age: ________ Daycare required? ❑ Yes ❑ No

Dietary restrictions ____

Photography consent ❑ Yes ❑ No *Yes indicates consent for VBF to use image on any VBF-owned website or program.*

ACCOMPANYING PERSON #2

First Name* ____

Last Name* ____

Relationship to patient ❑ Mother ❑ Father ❑ Grandparent ❑ Sibling ❑ Guardian ❑ Other/Friend

Under Age 13 ❑ Yes ❑ No Indicate age: ________ Daycare required? ❑ Yes ❑ No

Dietary restrictions ____

Photography consent ❑ Yes ❑ No *Yes indicates consent for VBF to use image on any VBF-owned website or program.*

ACCOMPANYING PERSON #3

First Name* ____

Last Name* ____

Relationship to patient ❑ Mother ❑ Father ❑ Grandparent ❑ Sibling ❑ Guardian ❑ Other/Friend

Under Age 13 ❑ Yes ❑ No Indicate age: ________ Daycare required? ❑ Yes ❑ No

Dietary restrictions ____

Photography consent ❑ Yes ❑ No *Yes indicates consent for VBF to use image on any VBF-owned website or program.*

All fields marked with an asterisk (*) are required.

SECTION 6: Conference Promotion

How did you hear about the VBF Conference and Clinics? *(check all that apply)*

- ❑ Dr. Linda
- ❑ Physician or Nurse
- ❑ Friend or Relative
- ❑ Day of Awareness Event
- ❑ VBF Website
- ❑ Internet Search
- ❑ Social Media
- ❑ Other ____

SECTION 7: For waiver applicants only

If requesting the conference registration fee waiver, the following fields are required:

Gender of applicant	❑ Male ❑ Female
Marital status	❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Never Married
Employment status (check all that apply)	❑ Full-time ❑ Part-time ❑ Not working ❑ Seeking employment ❑ Self-employed ❑ Salaried ❑ Employed for wages ❑ Student ❑ Retired ❑ Homemaker ❑ Unable to work
Housing	❑ Rented ❑ Owned by you or someone in the household with a mortgage or loan? ❑ Owned by you or someone in the household free and clear (without a mortgage or loan)? ❑ Occupied without payment of cash rent?
Household Income	❑ Less than $10K ❑ $10K - $19K ❑ $20K - $29K ❑ $30K - $39K ❑ $40K - $49K ❑ $50K - $59K ❑ $60K - $69K ❑ $70K - $79K ❑ $80K - $89K ❑ $90K - $99K ❑ $100K - $149K ❑ More than $150K
Ethnicity	❑ Hispanic or Latino ❑ NOT Hispanic or Latino
Race (optional)	❑ American Indian or Alaska Native ❑ Asian or South Asian ❑ Black or African-American ❑ Native Hawaiian or Other Pacific Islander ❑ White or Caucasian ❑ Other

Return this form with payment to
Vascular Birthmarks Foundation, PO Box 106, Latham, NY 12110

Questions? Please contact conference.vbf@gmail.com

All fields marked with an asterisk (*) are required.