REGISTRATION FORM

Follicular Unit Extraction: State of the Art Methodology and Instrumentation

ISHRS Regional Workshop
Hosted by James A. Harris, MD, FACS
Denver, Colorado, USA
October 2-3, 2009

One form per person. Please make copies if needed. Due to limited space we are unable to accommodate any staff members. **This workshop is limited to physicians only. Each attendee must bring 3.5-6.5 power magnification loupes/glasses for the workshop.**

Name:______________________________

Address:______________________________

City:______________________________ State/Region:______________________________

Zip/Postal Code:______________________________ Country:______________________________

Telephone:______________________________ Fax:______________________________

Please include country code for Telephone and Fax

E-mail:______________________________

Special Dietary Request (e.g. kosher, vegetarian), please indicate: ______________________________

Dinner: We are pleased to host a dinner for all seminar attendees and their spouses on Friday, October 2, 2009, at Cool River Café.

Hotel: Hyatt Place Denver Tech Center, 8300 E. Crescent Pkwy Greenwood Village, CO 80111. Please email your hotel reservation request to Deborah Mounier: deborah.mounier@hyattselect.com Please Identify that you are with The Dr. James Harris group. She will reserve your room and respond your confirmation via email. We have a block of rooms with a special rate of $74.00 per night (single/double). **Deadline** for hotel reservation **September 14, 2009**

Cancellation/Refund Policy

Registration fees, less a $100.00 (USD) administration fee, will be refunded upon written notice of cancellation to the Workshop Registrar received on or before September 10, 2009, there will be no refund of fees for cancellation or for lack of attendance without notification. It is your responsibility to ensure that your cancellation request has been received by the workshop Registrar. "No shows" that have not pre-paid will be invoiced for the total registration fee.

Registration Fees:
Fees are denoted in U.S. Dollars.

- ❑ Physician – ISHRS Member................................$2,200.00
- ❑ Physician – Pending Member............................$2,500.00
- ❑ Physician – Non Member $2,700.00

TOTAL: $______________________________

Payment:

❑ If paying by check, make payable in U.S. dollars to:
Hair Sciences Center of Colorado

❑ If paying by credit card: ❑ Visa ❑ MasterCard ❑ Discover

Card Number:______________________________ Expiration Date:______________________________

Name on Card:______________________________

Authorized Signature:______________________________

Allow 5 business days for processing. A confirmation letter will be emailed to you. If you do not receive a confirmation letter, please contact the Workshop Registrar. If paying by credit card, a charge from *Hair Sciences Center of Colorado* will appear on your next statement.

Questions? Contact the Workshop Registrar, Janiece McCasky, at telephone 303-694-9381 or e-mail jmccasky@hsccolorado.com.

Fax completed form to: 303-694-9373

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Attendee Participation Agreement

(All registrants must read and sign this Agreement.)

I hereby request and consent to participate as an attendee at the at the ISHRS Regional Live Surgery Workshop entitled, "Follicular Unit Extraction: State of the Art Methodology and Instrumentation" to be held on October 2-3, 2009, at The Hair Sciences Center of Colorado, 5445 DTC Parkway, Ste. 1015, Greenwood Village, CO, 80111, USA (the "Workshop").

I understand that the material presented at the Workshop has been made available under sponsorship of the International Society of Hair Restoration Surgery ("ISHRS") for educational purposes only. This material is not intended to represent the only, nor necessarily the best, method or procedure appropriate for the medical situations discussed, but rather is intended to present an approach, view, statement or opinion of the faculty which may be of interest to others.

I understand and acknowledge that volunteer patients have been asked to participate in the Workshop for educational and training purposes. I represent and warrant that I shall keep confidential the identity of, and any information I may receive during the Workshop regarding, such volunteer patients.

I am aware that this program offers the opportunity to perform the procedure on actual patients. In order to participate **in hands-on experience with the workshop patients** I must be a licensed physician in good standing with the appropriate medical board in **the United States or United States territories and that I carry the appropriate medical malpractice insurance for the state or states in which I am licensed.** I hereby declare that I am a licensed physician in good standing with the appropriate state/country medical licensing board. **I understand that if I am not licensed in the United States or United States territories that my hands-on experience will be limited to cadaveric scalp tissue and not an actual patient.**

I further represent and warrant that I shall adhere to universal precautions during the Workshop, and that I shall conform to all proper medical practices and procedures for the treatment of patients for whom no medical history is available when coming into contact with such patients, as well as with cadaveric specimens or cadaveric material. In the event that I incur a needle stick injury, cut, or other exposure to blood borne pathogens, I shall immediately notify the Program Director and the ISHRS and take such other follow-up measures as deemed appropriate.

I further understand and agree that I cannot reproduce the Workshop, or portions thereof, in any manner, including, without limitation, by photograph, audiotape, or videotape. All property rights in the material presented, including common law copyright, are expressly reserved to the presenter or to the ISHRS. The Workshop may be audiotaped, videotaped, or photographed by the ISHRS. I expressly grant the ISHRS permission to record my voice and/or my image by audiotape, videotape, and/or still photography during such Workshop, and I hereby waive any and all rights in and to such recordings.

The ISHRS is not responsible for expenses incurred by an individual who is not confirmed and for whom space is not available. Costs incurred by such individuals, such as airline or hotel fees or penalties, are their responsibility.

As a condition of my participation, I hereby waive any and all rights, actions, and claims I may have against the Program Director, and the ISHRS, its directors, officers, members, employees and agents, or against the presenters or speakers, and release and discharge them from and against any and all liability for damage, injury, or disease that may arise from my participation or attendance at the Workshop, including, without limitation, the manner in which the Workshop is conducted and the information is presented.

By signing below and/or registering for the Workshop, I agree to be bound by the terms of this Attendee Participation Agreement and to abide by all other policies and procedures of the ISHRS and The Hair Sciences Center of Colorado.

Signature:____ Date:________________________

Printed Name:____