



REGISTRATION FORM

This meeting is free. Patients, caregivers and healthcare professionals are welcome to attend.

Being held at: Hotel Halifax, 1990 Barrington Street, Halifax, NS, B3J 1P2

Nightly room rate of \$199.00 is available.

To receive this rate hotel rooms must be booked by September 16, 2020. Call the Hotel Halifax on 1-833-357-8155 to reserve a room. Those who would like to book online can use the link <http://bookings.ihotelier.com/bookings.jsp?groupID=2671310&hotelID=108084>

Information obtained on this form will be kept confidential and will not be shared with any other organization. Health information is used for statistical purposes and to assist AAMAC better serve the needs of patients.

REGISTRATION INFORMATION

Last name: _____ First Name: _____

Address: _____

Email Address: _____

Home phone #: _____ Cell phone #: _____

I am a (please circle):	Patient	Family/ Friend	Healthcare Professional	Name of Organization:
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Disease Type (please circle):	AA	MDS	PNH	Other (specify):	Date of Diagnosis:
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We encourage sharing and networking at the meeting and can specify your disease type on your name tag to facilitate networking. Please indicate if you would like your disease type on your name tag: Yes No

How did you hear about the meeting? (please circle)

Family/Friend Healthcare Professional Newsletter Website Other (specify):

THERE ARE A LIMITED NUMBER OF TRAVEL SPONSORSHIPS AVAILABLE - MAXIMUM OF \$500 PER FAMILY. IF YOU REQUIRE FINANCIAL ASSISTANCE, PLEASE INDICATE BELOW

Travel Sponsorship Requested: Yes No

Once travel sponsorship is approved, you will be provided with an expense form to be completed after Patient Education Day. Original receipts will be required. Expenses must be related to travel: meals (excluding alcohol), gas, mileage, airfare, taxi and hotel accommodations.

I would like to be added to the mailing list to receive updates, newsletters and other information Yes No

Preferred Method of Communication (please circle): Paper Mail Email

Breakfast, lunch and snacks will be provided. Do you have special dietary needs and/or food allergies? If so, please indicate: _____ Yes No

We look forward to seeing you on Patient Education Day!

Please submit registration form to:

Email: info@aamac.ca or **mail:** 2201 King Road, Unit #4, King City, ON L7B 1G2