

# Registration Form

Wednesday, December 1, 2010

\_\_\_\_\_  
Name Title

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Contact Number

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Hospital Affiliation

Registration Fee: \$65.00 \_\_\_\_\_

Break Out Sessions: *Please Check One:*

- 1:00 p.m. - 1:45 p.m.
- Social Security Disability Law & Patient's Rights
  - Care Coordination & The Medical Home

Method of Payment:

- Check: Made Payable to: Sickle Cell Disease Association of Illinois or SCDAI
- Via Pay Pal On-line: [www.sicklecelldisease-illinois.org](http://www.sicklecelldisease-illinois.org)

**Please detach this form and submit with payment or  
Register Online at  
[www.sicklecelldisease-illinois.org](http://www.sicklecelldisease-illinois.org)**

8100 S. Western Ave .Chicago, Illinois 60620  
Phone: (773) 526-5016 Fax: (773) 526-5012