If you'd like to register online or for more information, visit **sts.org/criticalcare**

1. REGISTRANT INFORMATION

□ I am an STS Member. Enter your valid 6-digit Member ID #: _____ □ I am NOT an STS Member

First Name **Last Name** **Designation (e.g., MD, RN)**

Job Title **Institution**

Mailing Address Street **City** **State/Province** **ZIP/Postal Code**

Email Address (required) **Phone (XXX-XXX-XXXX)**

Profession

□ Academic Researcher
□ Allied Health – Other
□ Anesthesiologist
□ Cardiologist
□ Cardiothoracic Surgeon
□ Cardiothoracic Surgery Resident
□ Clinical Nurse Specialist
□ Data Manager
□ General Surgery Resident
□ Industry Employee
□ Medical Student
□ Nurse Practitioner
□ Perfusionist
□ Physician Assistant
□ Physician – Other
□ Practice Administrator
□ Pulmonologist
□ Registered Nurse
□ Other: _____

Practice

□ Academic Medicine (medical school or university)
□ Academic Medicine w/ ACGME-approved CT surgery residency program
□ Government
□ HMO Employed
□ Hospital Employed
□ Private Practice – small (1-3 surgeons)
□ Private Practice – large (4+ surgeons)
□ Other (please specify): _____

Percentage of time you devote to (must equal 100%):

Adult Cardiac Surgery ____%
Adult Congenital Cardiac Surgery ____%
Critical Care ____%
General Thoracic Surgery ____%
Pediatric Congenital Cardiac Surgery ____%
Vascular Surgery ____%
Other ____% (please specify)_____

How did you hear about the 17th Annual Perioperative and Critical Care Conference?

□ Email □ Social Media □ Colleague □ Other:_____

2. REGISTRATION SELECTION (Please check only one)

	Member		Non-Member	
	Early Bird	**After Sept. 7**	**Early Bird**	**After Sept. 7**
Physician	□ $175	□ $250	□ $250	□ $350
Allied Health	□ $100	□ $150	□ $150	□ $200
Resident	□ $75	□ $100	□ $100	□ $150

3. PAYMENT

Please make check payable to "The Society of Thoracic Surgeons". Mail the check and this form to:
The Society of Thoracic Surgeons, PO Box 809308, Chicago, IL 60680-9308