

AMERICAN SPINAL DECOMPRESSION SOCIETY ANNUAL SYMPOSIUM

April 9th-10th, 2027 | USF CAMLS - 124 S Franklin St. Tampa, FL 33602

1 ATTENDEE INFORMATION

Provider Name: _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Mobile Phone: _____

Chiropractic License #: _____ License Expiration: _____

2 REGISTRATION OPTIONS (Please check all that apply)

☐ ASDS Member Registration — **\$195**

☐ Non-Member Registration - **\$395**

☐ Join ASDS + Event Registration — **\$590**

☐ Staff of an **ASDS Member** (Students, Faculty & Clinical Staff) — **\$100**

☐ Staff of **Non-ASDS Member** — **\$295** (Must register with a doctor or clinic owner.)

 **Total Attendees** (Including Yourself): _____

 **Order Total: \$** _____

Staff Names (First & Last): _____

3 PAYMENT INFORMATION

Card Number: _____ Exp: _____ / _____

Card Type: ☒ VISA ☐ American Express ☐ MasterCard ☐

Authorized Amount: \$ _____ CVC Code: _____

I, _____, authorize the American Spinal Decompression Society, Inc. to charge the above credit card for this order. All sales are final subject to ASDS cancellation terms.

Print name

Card Holder Signature

Date

For Submission Please Email to: Abby@excitemedical.com or Fax +1-888-408-0407

Membership terms: *American Spinal Decompression Society, Inc. memberships renew automatically each year at \$395. A written cancellation notice is required at least 30 days prior to the first renewal or any time thereafter.