TOUR REGISTRATION FORM

Reservations can be faxed to **1-954-771-1134** or mailed to **Professional Travel Abroad:**
2929 E. Commercial Blvd., Suite #201 • Fort Lauderdale, FL 33308

Call a PTA Advisor to help you complete this form and make your reservation.
1-954-771-8228 or **1-800-962-9199** - Monday-Friday 9:00 A.M. – 6:00 P.M. (EST)

TOUR INFORMATION

CME Tour Name ______________________ Departure Date ________

❑ Do you need assistance connecting flights from home city to gateway? Airport code ______

Do you wish to request business class? ❑ Yes ❑ No

Tour Extension ______________________

Number of CME participating Physicians ________ Registration is $295 per Physician.

PERSONAL INFORMATION

Kindly register with your name **exactly as it reads on your passport**

First ____________ Middle ____________ Last ____________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Gender ❑ Male ❑ Female Date of Birth ____________
Day/Month/Year

Street Address ______________________

City/State/Zip Code ______________________

Home Phone ____________ Cell Phone ____________ Fax ____________

Medical Specialty ____________ E-Mail ____________

ACCOMPANYING PERSON(S)

First ____________ Middle ____________ Last ____________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Gender ❑ Male ❑ Female Date of Birth ____________
Day/Month/Year

Medical Specialty ______________________

First ____________ Middle ____________ Last ____________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Gender ❑ Male ❑ Female Date of Birth ____________
Day/Month/Year

Medical Specialty ______________________

First ____________ Middle ____________ Last ____________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Gender ❑ Male ❑ Female Date of Birth ____________
Day/Month/Year

Medical Specialty ______________________

Type of room (request): ❑ Single ❑ Double ❑ Twin ❑ Triple

PAYMENT INFORMATION

A deposit must be received with this Registration Form:
$300 per person or **$750** per person for cruise programs.

Check must be made payable to **Professional Travel Abroad**

Please charge my deposit of $ ________ on my credit card.

Name on Card ______________________

Card Type ❑ Visa ❑ MasterCard ❑ American Express

Card Number ______________________ Expiration Date ________

Credit Card Signature ______________________

TERMS OF AGREEMENT

By sending this form, I understand and accept the terms and conditions outlined in PTA brochure and website.