



Thursday, May 14th 5:40 – 8:00 pm
Marian University

Returning to Sports after Knee Injury
Scott Lawrance, DHS, ATC, MSPT, CSCS
Rodney Benner, MD

Please mail or fax this form with your payment to:

Shelbourne Knee Center
Attn: Diane Davidson
1815 N. Capitol Ave. Suite 600
Indianapolis, IN 46202

Fax: 317.921.0230
Phone: 317.924.8670
Email: ddauidson@fixknee.com

PT PTA ATC MD PA Other: _____

First Name: _____ Last Name: _____

Hospital or Practice Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Special Dietary Needs? Veg GF
(required for confirmation)

Payment: Advanced Registration (rec'd by 5/11/15) On-Site Registration (cash or check only) <small>*Students please include a copy of your student ID with your registration</small>	Professional <input type="checkbox"/> \$50 <input type="checkbox"/> \$65	Full-Time Student* <input type="checkbox"/> \$25 <input type="checkbox"/> \$40
<input type="checkbox"/> Check enclosed (payable to: Shelbourne Knee Center) <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express		

Cardholder's Name: _____
As it appears on the card

Card Number: _____ Exp Date: _____

Signature: _____ CSC Code: _____
(from back of card)

Once we have received and processed your registration and payment, we will send an email confirming your registration.

For Office Use Only:
Registration Received on _____ Date Processed/Check# _____ Confirmation Sent _____