

NEUROINFORMATICS 2003

REGISTRATION FORM

PLEASE COMPLETE AND RETURN THIS FORM TO Ms. KATHLEEN CLINTON
AT THE ADDRESS BELOW BEFORE FEBRUARY 28, 2003.

NAME

FIRST NAME: _____

LAST NAME: _____

TITLE: _____

ADDRESS

DEPARTMENT: _____

INSTITUTION: _____

MAILING ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

COUNTRY (IF OTHER THAN USA): _____



CONTACT INFORMATION

TELEPHONE: _____

FAX: _____

E-MAIL: _____

STATUS (✓)

FACULTY:

POSTDOC:

GRADUATE STUDENT:

UNDERGRADUATE:

OTHER:

FEE

\$10.00

\$ 5.00

\$ 5.00

\$ 5.00

\$10.00

**N.B. BOX LUNCH IS INCLUDED
IN THE REGISTRATION FEE.**

METHOD OF PAYMENT

CUFS NUMBER (PROVIDE): _____

CASHIER'S CHECK (✓):

PERSONAL CHECK (✓):

**CHECKS SHOULD BE MADE OUT TO "UNIVERSITY OF MINNESOTA" AND SENT TO Ms.
KATHLEEN CLINTON, MMC 451 MAYO, 420 DELAWARE STREET S.E., MINNEAPOLIS,
MN 55455.**

BOX LUNCH ON FRIDAY, APRIL 25 (YES,NO):

DIETARY RESTRICTIONS, IF ANY: _____

POSTER PRESENTATION (YES,NO):

IF YES, TITLE: _____

NAME AND INSTITUTION TO APPEAR ON NAME-TAG

NAME: _____

INSTITUTION: _____

**FOR ADDITIONAL INFORMATION CONTACT Ms. KATHLEEN CLINTON:
612-625-8424 (VOICE); 612-625-9442 (FAX)
E-MAIL: CLINTON@COMPNEURO.UMN.EDU**