

Conference Registration

Registration due by September 8, 2008 (space is limited)

Name of person(s) attending conference:

Name	Age	Does this person have sickle cell disease?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ () _____
 Home Work Cell Home Work Cell

Do you need transportation assistance? Yes No

If YES, please contact the Sickle Cell Disease Foundation of California to make reservations.
310-693-0247

Do you need Spanish translation? Yes No

Please complete the enclosed child care form if needed

Please return this form to the SCDFC by mail or fax by September 8th:

Sickle Cell Disease Foundation of California
6133 Bristol Parkway, #240
Culver City, CA 90230
Fax: (310) 693-0266