2020 DENVER X-RAY CONFERENCE
REGISTRATION FORM

Bethesda North Marriott Hotel & Conference Center • Maryland, USA • 3 - 7 August 2020

For Name Tag and Attendee List:

First Name _____ Last Name _____

Organization _____

Address _____

City _____ State _____ Zip _____

Country _____ Phone _____ Email _____

☐ Check this box if you **Do Not** want your name included on the attendee list.

Registration Fees: Discount fees will only apply if registration form and payment are received by 1 July 2020.

	by 1 July	after 1 July
○ Full week: exhibits, workshops, sessions	$775	$850
○ Monday & Tuesday: exhibits, workshops	$725	$800
○ Wed., Thurs. & Friday: exhibits, sessions	$725	$800
○ Presenter from Participating Exhibit Company	$375	$375
○ Session organizer, invited speaker	$350	$350
○ Workshop instructor	$325	$325
○ Student (I.D. required)*	$325	$400
○ 65 and older (I.D. required)*	$400	$475

All registrations include access to the conference proceedings on-line, Volume 64, *Advances in X-ray Analysis*.
*Students and those 65 and older are required to include identification with their registration form.

To Submit Registration Form; SAVE A COPY AND EMAIL TO: dxc@icdd.com

OR: **Fax:** 610.325.9823
Mail: ICDD, Conference Services Department, 12 Campus Boulevard, Newtown Square, PA 19073-3273 USA

ICDD reserves the right to use any and all photographs taken throughout the conference to promote the conference without additional approval from you, the participant.

Cancellation Policy: Cancellations must be submitted in writing to ICDD's Conference Services Department (dxc@icdd.com). A full refund will be issued, less a $50 processing fee, if the cancellation is received at least two weeks before the conference (Monday, 20 July 2020). No refunds will be issued for cancellations received after 20 July 2020. Please contact ICDD's Conference Services Department for any additional information, e-mail: dxc@icdd.com or phone: 610.325.9814.

Payment: Total Amount Due: $ _____

☐ Check enclosed for _____ made payable to ICDD/DXC in U.S. dollars and drawn on a U.S. bank.

Charge my: ○ Visa ○ Mastercard ○ American Express

Billing address, if different from above: (address that the credit card is registered)

First Name _____ Last Name _____

Organization _____

Address _____

City _____ State _____ Zip _____

Country _____ Phone _____ Email _____

Card number _____ CVV# _____ Expiration Date _____

Cardholder's name (please print) _____

Cardholder's signature (optional) _____