



12TH ANNUAL NATIONAL CJD CONFERENCE

SATURDAY 26TH OCTOBER 2019

JASPAR HOTEL- FUNCTION HALL, 489 ELIZABETH STREET, MELBOURNE VIC 03 8327 2777

REGISTRATION DETAILS

Last Name: First Name:.....

Organisation/Company/Family:

Contact Number: Email:

- I am a recipient of hPH
- I am a CJD family member or friend
- I am a health care professional
- I am a researcher or student

EVENT DETAILS

Date	Event	Time	Details
Saturday 26 th October	All Day Conference	08:30AM-5:00PM	Full day conference including morning and afternoon tea and lunch.
Saturday 26 th October	Conference Dinner	7:00 PM	Dinner includes a 3-course meal and soft drinks (alcoholic drinks available for purchase).
Friday 25 th October	Genetic Meeting	2:30PM	This meeting is for genetic family members or those wanting to understand more about testing. A safe environment to ask questions of experts and support each other.

REGISTRATION FEE

	Healthcare Professional		Family Member/ At Risk Group		Member of the prion research community	
	Number		Number		Number	
All Day Conference Saturday 26 th October 2019		\$ 60.00		\$ FREE		\$ FREE
Genetic Family Meeting* Friday 25 th October 2019		N/A		\$ FREE		N/A
Conference Dinner 7pm, Saturday 26 th October 2019		\$ 50.00		\$ 50.00		\$ 50.00

*Registration only for family members affected by genetic CJD or other prion diseases and family members seeking advice on genetic testing.

Specific diet requirements (vegetarian, allergies)

CANCELLATION POLICY

All cancellations received up to Friday 18/10/19 will be fully refunded, after which time no refund will be provided. Replacements by colleagues or other family members, i.e. transfer of the registration at no extra cost, are much welcome.

PAYMENT

<input type="checkbox"/> BANK TRANSFER	All charges to be borne by principal, to the order of the CJDSGN		
Account Holder:	CJDSGN Australia	Bank Name:	Commonwealth Bank
BSB: 06 2313	Account No. 10183525	Please include Delegate's name on transfer	
<input type="checkbox"/> CREDIT CARD:	<input type="checkbox"/> American Express	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
Cardholder	.....	Amount:	.....
Card #:	.....	Expiry date:	.....
		Security Code (CVC):	.....
Date:	.....	Signature:	.....

Receipt/Confirmation will be emailed.

NAMES OF ATTENDEES

Last Name: First Name:.....

Last Name: First Name:.....

Last Name: First Name:.....

Last Name: First Name:.....

PLEASE COMPLETE THIS FORM AND RETURN TO THE CJDSGN BY 16/10/19

Email: contactus@cjdsupport.org.au (PDF form to return via email)

Post: CJDSGN, 13 Araluen Place, Glenhaven NSW 2156

Call to register and pay 1800 052 466

Register and/or pay online: conference.cjdsupport.org.au

The CJDSGN acknowledge the funding provided by The Australian Government Department of Health that assists towards the cost of this conference.