Caribbean Nurses Organization: 27th Biennial Conference
Aruba: October 24 - 29, 2010

REGISTRATION FORM

Registration number: ____________________
(internal use)

Complete this form and send it as soon as possible to the Aruba Nurses Organization (ODEA).
While filling in this form please follow the instructions closely.
If using electronic registration form (scan or any other form) please have original form when registering.

Please print clearly in UPPERCASE.

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1 PERSONAL INFORMATION

Surname: ________________________________ ( ) Mr. ( ) Mrs. ( ) Miss ( ) Prof. ( ) Dr.

First name: _______________ Middle Initials: ____________ Date of Birth: _ _ / _ _ / _ _ _ _

Present Occupation: _______________________________ Religion _____________________

Position in NNA: ____ Voting Delegate : yes / no

Mailing address: ____

Number and street: ____

Zip code: __________ City/State: __________________ Country: _______________________

Telephone: ____________________________ Fax: ___________________________________

E-mail: ____

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2 TYPE OF REGISTRATION:

mark all that applies

ARUBA RESIDENTS NON-ARUBAN RESIDENTS

HOTEL-STAY NON-HOTEL STAY

Non-Hotel Stay must pay for Opening and Closing Ceremony, Cultural and Surinam Night

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3 FLIGHT INFORMATION

Date of arrival _________________________ Time of arrival ___________________________

Airline _______________________________ Flight number ___________________________

Date of departure ______________________ Time of departure ________________________

Special requirements upon arrival/departure ____

____

Registration fee includes: access to the conference, conference kit and badge, transportation (between airport and hotel) and field trips.
Opening Ceremony, Cultural Night, Surinam Night, Island Tour and Closing Ceremony
For local, non-hotel stay and daily registrant a Fee of $ 50.00 would be charged.

4 REGISTRATION FEES:

mark X where applies

Early registration: *Prior to July 1st, 2010*

- Nurses : USD 300.00 ___
- Retired Nurses : USD 250.00 ___
- Students : USD 150.00 ___
- Other Professionals or accompanying persons: USD 400.00 ___

Late registration: *From 1st of July 2010 till 31st of August 2010*

- Nurses : USD 350.00 ___
- Retired Nurses : USD 275.00 ___
- Students : USD 175.00 ___
- Other Professionals or accompanying persons: USD 450.00 ___

After August 31st, 2010: *Daily Registration*

- Nurses USD 50.00
- Retired Nurses & Students USD 30.00
- Other Professionals or accompanying persons USD 60.00

(A) Total Registration FEES: USD ________________

Payment of registration fee as follows: Make fees payable to the Aruba Nurses Organization special account:
ODEA-CNO Conference account 2010
Financial Institution: Caribbean Mercantile Bank
Country: Aruba
Swift code: CMBAAWAX
Account Number: 606.979.07

5 SPECIAL REQUIREMENTS

Special requirements during conference ____

Dietary ____

Accommodations for people with handicap needs ( ) Yes / ( ) No

(describe what kind of handicap):____

____

____

Special Medication and/or medical needs ( ) Yes / ( ) No

(describe what kind of special medication and/or medical needs):___________________________

____

____

6 HOTEL REGISTRATION

Hotel registration Holiday Inn SunSpree Resort

Hotel accommodations will only be reserved upon receipt of payment (for two nights).
Payment should be made payable to the Aruba Nurses Organization special account : ODEA-CNO Conference account 2010.)

Room Rates

All prices include an all-inclusive plan (all breakfast, lunch and dinner included/taxes).

				Number of nights
Single	USD	210.00	per person/per night	_____
Double	USD	145.00	per person/per night	_____
Triple	USD	125.00	per person/per night	_____
Ages 12-17	USD	50.00	per person/per night	_____
Children 11 & under	Free			_____

Total Room Rates USD _________________ (number of nights X room rate)
(B) Total reservation amount USD _________________ $^{-}/_{-}$ (2 X room rate)
(D) Pending payment for Hotel USD _________________

Please indicate below the name(s) of person(s) who will be sharing rooms, also indicate with an X if that person is a relative, if applicable:

Relative Name

___ ____

___ ____

___ ____

7 TOTAL AMOUNT

(A) Total Registration FEES USD _________________
(B) Total reservation amount USD _________________ $^{+}/_{+}$
(C) Total amount to be sent to ODEA USD _________________

(D) Pending payment for Hotel USD _________________

ODEA-CNO Conference account 2010
Financial Institution: Caribbean Mercantile Bank
Country: Aruba
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Account Number: 606.979.07

Registration number: ....

8 NATIONAL NURSES ASSOCIATION

Name of your National Nurses Association: ____

Name and Signature of the President of the Association is requested.

Complete name ____ Date _ _ / _ _ / _ _ _ _

Signature _____________________________________ Title ____________________________

Nurse
Retired Nurse
Student Nurse
Other - Specify ____

Date _ _ / _ _ / _ _ _ _ Registrant Signature ____

For more information on other accommodation please contact

Aruba Nurses Organization

Paradera 175 F apt. 5	P.O. Box 3034
Paradera	Santa Cruz
Aruba	Aruba

Telephone or fax	00 11 297 5820274
Website	www.arubanurses.org
E-mail	cnoconference@arubanurses.org

If using an electronic registration form
PLEASE have original form when registering at the hotel.

Registration number: ....