



Cowgirl Hair Loss Workshop
The Art and Science of Helping Women with Hair Loss

ISHRS Regional Workshop
Hosted by Carlos J Puig DO, FISHS
Houston, Texas, USA

March 19-22, 2020

REGISTRATION FORM

One form per person. Please make copies if needed.

Name: _____

Address: _____

City: _____ State/Region: _____

Zip/Postal Code: _____ Country: _____

Telephone: _____ Fax: _____

Please include country code for Telephone and Fax

E-mail: _____

Special Dietary Request (e.g. kosher, vegetarian), please indicate: _____

Dinner: We are pleased to host a dinner for all seminar faculty, attendees and their spouses on Friday, March 20,2020 at Fuad's. Alternative foods will be on the menu.

Hotel: Westin Galleria, 5011 Westheimer, Houston, Texas 77056. Reservations can be made by calling US & Canada: **1-888-627-8457**. Please Identify that you are with Cowgirl Hair Loss Workshop, sponsored by Physicians Hair Restoration Center and ISHRS. We have a block of rooms with a special rate of \$169.00 per night (single/double). **Deadline** for hotel reservation **February 18, 2020**.

Cancellation/Refund Policy

Registration fees, less a \$100.00 (USD) administration fee, will be refunded upon written notice of cancellation to the Workshop Registrar received on or before March 1, 2013. There will be no refund of fees for cancellation or for lack of attendance without notification. It is your responsibility to ensure that your cancellation request has been received by the workshop Registrar. "No shows" that have not pre-paid will be invoiced for the total registration fee.

Registration Fees:

Fees are denoted in U.S. Dollars.

- Physician – ISHRS Member \$1,200.00
- Physician – Non Member \$1,400.00
- Non Attendee Food & Beverage (Spouse/Guest) \$225.00

TOTAL: \$ _____

Payment:

If paying by check, make payable in U.S. dollars to:
Physicians' Hair Restoration Center

If paying by credit card: Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

Name on Card: _____ Billing Zip Code: _____

Authorized Signature: _____

Allow 5 business days for processing. A confirmation letter will be emailed to you. If you do not receive a confirmation letter, please contact the PHRC office 713.974.1808. If paying by credit card, a charge from *Physicians' Hair Restoration Center* will appear on your next statement.

Questions? Contact the Workshop Registrar, Diana Rohani, at telephone 713.974.1808 or e-mail frontdesk@HairRestorationHouston.com.

Fax completed form to 713.974.1811 or Email to Frontdesk@HairdocTexas.com



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Attendee Participation Agreement

(All registrants must read and sign this Agreement.)

I hereby request and consent to participate as an attendee at the at the ISHRS Regional Live Surgery Workshop entitled, "Cowgirl Hair Loss" to be held on March 19-22, 2020, at the offices of Physicians Hair Restoration Center, 6150 Richmond Ave, Suite 226, Houston Texas 77057, the "Workshop".

I understand that the material presented at the Workshop has been made available under sponsorship of the International Society of Hair Restoration Surgery ("ISHRS") for educational purposes only. This material is not intended to represent the only, nor necessarily the best, method or procedure appropriate for the medical situations discussed, but rather is intended to present an approach, view, statement or opinion of the faculty which may be of interest to others.

I understand and acknowledge that volunteer patients have been asked to participate in the Workshop for educational and training purposes. I represent and warrant that I shall keep confidential the identity of, and any information I may receive during the Workshop regarding, such volunteer patients.

I further represent and warrant that I shall adhere to universal precautions during the Workshop, and that I shall conform to all proper medical practices and procedures for the treatment of patients for whom no medical history is available when coming into contact with such patients, as well as with cadaveric specimens or cadaveric material. In the event that I incur a needle stick injury, cut, or other exposure to blood borne pathogens, I shall immediately notify the Program Director and the ISHRS and take such other follow-up measures as deemed appropriate.

I further understand and agree that I cannot reproduce the Workshop, or portions thereof, in any manner, including, without limitation, by photograph, audiotape, or videotape. All property rights in the material presented, including common law copyright, are expressly reserved to the presenter or to the ISHRS. The Workshop may be audio taped, videotaped, or photographed by the ISHRS. I expressly grant the ISHRS permission to record my voice and/or my image by audiotape, videotape, and/or still photography during such Workshop, and I hereby waive any and all rights in and to such recordings.

The ISHRS is not responsible for expenses incurred by an individual who is not confirmed and for whom space is not available. Costs incurred by such individuals, such as airline or hotel fees or penalties, are their responsibility.

As a condition of my participation, I hereby waive any and all rights, actions, and claims I may have against the Program Director, and the ISHRS, its directors, officers, members, employees and agents, or against the presenters or speakers, and release and discharge them from and against any and all liability for damage, injury, or disease that may arise from my participation or attendance at the Workshop, including, without limitation, the manner in which the Workshop is conducted and the information is presented.

By signing below and/or registering for the Workshop, I agree to be bound by the terms of this Attendee Participation Agreement and to abide by all other policies and procedures of the ISHRS and Physicians' Hair Restoration Center.

Signature: _____ Date: _____

Printed Name: _____