

Practical Clinic Participant Agreement Waiver and Release Form



2008 AANS ANNUAL MEETING | Chicago, IL | April 26-May 1, 2008

Name				Daytime Phone Number <i>(include country code if applicable)</i>		Fax Number	
Address				Preferred E-mail Address			
City		State	Zip	Country			
Please place personalized label here.							

Registration deadline is March 24, 2008

IMPORTANT This form must be completed and sent in with your registration in order to register for the Practical Clinics.

Infectious Disease Transmission Safeguard

I am aware of the means of transmission of infectious diseases, including the human immunodeficiency virus (HIV), and agree that all possible precautions should be made to prevent any transmission of infectious diseases, including HIV. I further understand that some risk exists that such transmission is possible merely through the handling of tissues, and that some of the tissues I will be handling in the clinic specified at the foot of this page may have been harvested from persons infected with HIV. Thus, as an inducement to the Association to accept my registration for and to permit my participation in this clinic, I agree to adhere to the following procedures when handling all tissues in this clinic:

1. I will handle all tissues with care to avoid contact with my skin or mucous membranes.
2. I will wear protective gloves at all times when handling the tissues.
3. I will observe extreme caution when using sharp instruments to avoid penetrating my or other's skin.
4. I will always use a surgical mask to prevent accidental exposure to fluid from tissues.

I hereby release and hold harmless the American Association of Neurological Surgeons and all Directors, Officers, Staff, and Instructors of the Association from, against, and with respect to any and all actions, suits, claims, damages, judgements, costs, and expenses of any and every kind and nature whatsoever, whether known or unknown, liquidated or unliquidated, fixed or contingent, direct or indirect, which I, my estate or any of my heirs, beneficiaries, successors, and assigns, and each of them, have or can have, shall or may have, or claim to have, against the Association and such Directors, Officers, Staff and, Instructors, and each of them, by reasons of my participation in this clinic and handling of tissues infected with any infectious diseases, including HIV.

Signature		Date	
Please Print Name			
Practical Clinic Number(s)			

RETURN FORM This form must be attached to your registration for Practical Clinics, or you will not be registered until it is received.

Mail to: AANS Registration Department, c/o Conference Technology Enhancements, Inc. (CTE), P.O. Box 2686, Des Plaines, IL 60018.
Fax to: 800-713-0796 (U.S.) or 847-297-5086 (International)

Do not send forms via Federal Express, UPS or Airborne. The only overnight service that will deliver to this address is the U.S. Postal Service.