

# Florida Municipal Attorneys Association – 29th Annual Seminar

## Amelia Island Plantation • July 29-31, 2010

Return completed form with registration fees to: Florida Municipal Attorneys Association, P.O. Box 1757, Tallahassee, FL 32302-1757; (850) 222-9684. Make checks payable to Florida Municipal Attorneys Association. Visa or MasterCard payments may be faxed to (850) 222-3806. Online registration also is available at [www.fmaa.us](http://www.fmaa.us).

**Please type or print information.**

Full Name: \_\_\_\_\_ First Name or Nickname: \_\_\_\_\_  
(as you wish it to appear on badge)

Title: \_\_\_\_\_ Representing: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

E-mail: \_\_\_\_\_

Spouse (if attending): \_\_\_\_\_ First Name or Nickname: \_\_\_\_\_  
(as you wish it to appear on badge)

Payment must accompany each registration	Qty.	Fee	Fee Paid
<b>Registration: On/Prior to July 9, 2010</b> <i>(Includes up to two reception tickets and one luncheon ticket)</i>	_____	@ \$ 250.00 = \$ _____	\$ _____
<b>Regular Registration: After July 9, 2010</b> <i>(Includes up to two reception tickets and one luncheon ticket)</i>	_____	@ \$ 270.00 = \$ _____	\$ _____
<b>Extra Luncheon Ticket</b> <i>(One included in registration)</i>	_____	@ \$ 25.00 = \$ _____	\$ _____
<b>Extra Reception Ticket</b> Children Ages 5-12	_____	@ \$ 15.00 = \$ _____	\$ _____
<b>Extra Reception Ticket</b> Children Ages 13 and Older/Adult <i>(Two included in registration)</i>	_____	@ \$ 25.00 = \$ _____	\$ _____
Total Fee Paid			\$ _____

Please indicate below the meal functions you plan to attend and if you will bring a spouse/guest.

I plan to attend the lunch:  Yes  No

I plan to attend the reception:  Yes  No

I also will have one spouse/guest attending the reception:  Yes  No

**Cancellation Policy:** Because of the requirement for advance attendance guarantees, cancellations must be received and confirmed by Friday, July 16, 2010.

**Note:** If you are physically challenged and require special services, or if you have special dietary needs, please attach a written description to this form.

Amount Enclosed: \$ \_\_\_\_\_ Method of Payment:  Check *(made payable to FMAA)*  Visa  MasterCard

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Billing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_ Cardholder's Phone: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_