



AHOMPR

ANNUAL MEETING 2025

OCTOBER 10-13, 2025
EL CONQUISTADOR RESORT

CONFERENCE REGISTRATION FORM

ALL INFORMATION STATED ABOVE WILL REMAIN CONFIDENTIAL TO AHOMPR

PLEASE TYPE OR PRINT:

Medical Licence #: _____

Name: _____ Medical Specialty: _____
Last Name Name Initial

Mailing Address: _____
Street Number Dept./Suite City State Zip Code

Office: _____ Cell: _____ Fax: _____

Home: _____ E-mail: _____

REGISTRATION RATES

REGISTRANTS	CASH / CHECK	CREDIT CARD
AHOMPR Members - Convention Package*	\$385.00	\$395.00
*The Convention Package includes all the social activities tickets for your companion. The hotel room for two nights (Friday through Sunday) will be paid by the Association. Physicians willing to stay one more night until Monday are responsible to pay \$249.00 plus tax to the hotel.		
AHOMPR Members - Educational Program**	\$275.00	\$285.00
Medical Liaison - Educational Program**	\$285.00	\$295.00
** These fees allows the registrant to participate in the conferences. Includes coffee break and lunch. Social activities and hotel room are not included.		
Non-Member Physicians***	\$500.00	\$525.00
*** These fees allows the registrant to participate in the conferences and social activities with spouse or companion.		

ADDITIONAL TICKETS

SOCIAL ACTIVITIES	CASH / CHECK	CREDIT CARD
Friday, October 10 • Welcome Activity	\$75.00 p/p	\$85.00 p/p
Saturday, October 11 • Night Activity	\$95.00 p/p	\$105.00 p/p
Sunday, October 12 • Family Activity (Pool Party)	\$75.00 p/p	\$85.00 p/p
Children (13 years old and under)	\$35.00 p/p	\$45.00 p/p

IMPORTANT: Please answer the following questions. Do you need **Child Care** for Friday and Saturday Night activities? YES NO
CHILD CARE available for Physicians' children ONLY. How many? BOY(S) - AGE(S) _____ / GIRL(S) - AGE(S) _____

HOTEL REGISTRATION

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Arrival / Llegada: _____ (Check-in time 3:00 pm) Departure / Salida: _____ (Check-out time 12 pm)
 Adults _____ Children _____ Room Type: King Bed _____ Two "Full" Beds _____
 Companion's Full Name _____
 Credit Card Guarantee / Tarjeta de Crédito _____ Exp. Date _____

Payment Type: Check (Please Enclose) Visa Master Card **(Sorry. No AMEX)**

Cardholder's Name: _____ Exp. Date: _____ Security Code#: _____

Card Number: _____ Signature: _____

Make all checks payable to:

Asociación de Hematología y Oncología Médica de PR
 PO Box 801195
 Coto Laurel PR 00780-1195

Cancellation Policy: In case of no show, one night stay penalty will be applied. Cancellations will be accepted with no penalty up to 72 hours prior to arrival. Penalty will be your responsibility



For more information:
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 Meeting Coordinator
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