

1. Your Information

Last _____
 First _____ MI _____
 ONS ID# _____
 Work place _____
 Work address _____
 City _____ State _____ Zip _____
 Home address _____
 City _____ State _____ Zip _____
 Country _____
 Phone (H) _____ (O) _____ (C) _____
 Fax _____
 Email _____

What pronouns do you use?
 He/Him She/Her They/Them Prefer not to say
 Prefer to self-describe: _____
 Do you want your pronouns displayed on your badge? Yes No
 I need a visa letter to attend the conference.
 My contact information may be released to third-party organizations such as conference satellite symposia sponsors and other organizations offering both ONS Congress and non-ONS Congress events, promotions, or information. Yes No
 Is this your first time attending ONS Congress? Yes No

2. Group Registration Pricing*

Register by March 7, 2024, to save!	EARLY BIRD	FINAL
Member/Associate Member	<input type="checkbox"/> \$563	<input type="checkbox"/> \$684
Nonmember	<input type="checkbox"/> \$828	<input type="checkbox"/> \$995

*Discounted pricing is only available for member and nonmember full conference registration. Additional registration options are available at ons.org/congress.

3. Join or Renew Your Membership (Optional)

Select the statement that best describes you.	1 Year
I am a Registered Nurse - 1 Year	<input type="checkbox"/> \$125
I am a Registered Nurse - 2 Year	<input type="checkbox"/> \$235
I am a nursing professional such as a nursing assistant, research assistant, or other nursing support staff	<input type="checkbox"/> \$63
I've been a Registered Nurse for five years or less	<input type="checkbox"/> \$94
I am a healthcare professional such as a physician, pharmacists, or industry employee - 1 year	<input type="checkbox"/> \$125
I am a healthcare professional such as a physician, pharmacists, or industry employee - 2 year	<input type="checkbox"/> \$235
I am a Registered Nurse who is 70 or older	<input type="checkbox"/> \$75
I am a full-time student working toward my RN	<input type="checkbox"/> \$0



2024 GROUP REGISTRATION FORM

Please submit this form via fax only. Valid one per customer toward the purchase of a full conference registration only. Not valid with any other offers or discounts. Offer valid for groups of 10 or more only and should not be forwarded or transferred to other customers or institutions. Please submit all (10+) group registration forms at once. If you have questions, contact ONS Customer Relations at 866-257-4ONS.

4. Discounted Hotel Reservations (Optional)

All reservations must be held with a credit card guarantee valid through May 2024. This guarantee is for arrival only, and a form of payment will be required upon check-in. No checks will be accepted for hotel payment.

Hotels	
Headquarter Hotel Marriott Marquis Washington, DC <input type="checkbox"/> Nightly Rate: \$433.65	
AC Hotel Washington, DC Convention Center <input type="checkbox"/> Nightly Rate: \$369.88	Courtyard Washington Downtown Convention Center <input type="checkbox"/> Nightly Rate: \$393.07
Embassy Suites DC Convention Center <input type="checkbox"/> Nightly Rate: \$410.47	Grand Hyatt Washington <input type="checkbox"/> Nightly Rate: \$451.05
Residence Inn Washington Downtown Convention Center <input type="checkbox"/> Nightly Rate: \$416.26	The Westin Washington, DC Downtown Hotel <input type="checkbox"/> Nightly Rate: \$426.70

Hotel rates are estimated per night for double occupancy and include current taxes and fees. For more hotel information, visit ons.org/congress.

Arrival date _____ Departure date _____
 List the names of those you will be sharing a room with (if applicable).
 Guest _____
 Guest _____
 Guest _____

5. Your Total

Sec. 2	\$
Sec. 3	\$
Sec. 4	\$
Total	

6. ONS Congress Terms and Conditions (Required)

I have read and agree to the ONS Congress Terms and Conditions, which include an arbitration agreement, a waiver of my right to bring a class action, and a liability waiver and release of claims. I intend that checking this box will have the same legal effect as if my signature were affixed to the ONS Congress Terms and Conditions.
 I have read and accept the Privacy Policy, the ONS Website Terms of Use, and consent to the given information being used to contact me about ONS Congress.
 I have read and agree to the Hotel Cancellation Policy.

OFFICE USE ONLY

Code: **CO24GRP**
 Date Rec'd _____ Amount _____
 Check #/Type _____

7. Special Accommodations

Pursuant to the Americans with Disabilities Act, I require special accommodations at the event location and/or hotel. Please indicate type of accommodations below:

Auditory Mobility Visual

Please provide further information, if needed: _____

We recognize that ONS Congress will be held over Passover. Please check here if you require kosher food options at any ONS Congress activity.

8. Your Payment Information

Check (made payable to Oncology Nursing Society) Check # _____

ONS gift certificate # _____ (include w/registration form)

Credit card* Visa MC AmEx Discover

Card number _____

Exp. date _____ CVVC# _____

Name as it appears on card (print) _____

Cardholder signature _____

Cardholder phone _____

*Credit card information is required to guarantee your hotel reservation.

Refund Policy

If you wish to cancel your ONS Congress registration, you must notify ONS by sending your request via email to help@ons.org. Refunds will be made in full (less a \$100 processing fee) when requested on or before March 7, 2024. Fifty percent refunds will be made (less a \$100 processing fee) when requested from March 8 through March 31, 2024. No refunds issued after March 31, 2024.

Submit Your Registration Now!

Fax**	Mail**
330-425-4983	Mail Stop 125 1375 N. Highway Dr. Fenton, MO 63099

Phone

866-257-4ONS (toll-free, U.S. and Canada)
 412-859-6100 (select option 2 for Customer Relations)
 Housing Inquiries: (864) 641-6757

**Please mail or fax forms that contain credit card information.

2024 REGISTRATION FORM

Date of Birth

____/____/____
 MM/DD/YYYY

What year did you earn your first nursing license?

Years Oncology Experience

Primary Position

- | | |
|--|--|
| <input type="checkbox"/> Academic Educator | <input type="checkbox"/> Care Coordinator |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Clinical Trials Nurse | <input type="checkbox"/> Consultant |
| <input type="checkbox"/> Executive | <input type="checkbox"/> Genetic Counselor |
| <input type="checkbox"/> Manager/Coordinator/Director | <input type="checkbox"/> Medical Science Liaison |
| <input type="checkbox"/> Nurse Informaticist | <input type="checkbox"/> Nurse Navigator |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Nurse Scientist |
| <input type="checkbox"/> Patient Educator | <input type="checkbox"/> Pharmaceutical Representative |
| <input type="checkbox"/> Quality Improvement Nurse/Coordinator | <input type="checkbox"/> Staff Educator |
| <input type="checkbox"/> Staff Nurse | <input type="checkbox"/> Student |
| <input type="checkbox"/> VP/CNO | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> None | _____ |

Highest Nursing Degree

- | | |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Associates | <input type="checkbox"/> Bachelor's |
| <input type="checkbox"/> Diploma | <input type="checkbox"/> DNP |
| <input type="checkbox"/> Master's | <input type="checkbox"/> PhD/DNSc |
| <input type="checkbox"/> None | |

Nursing License Status

- | | |
|--|----------------------------------|
| <input type="checkbox"/> APRN/CNS | <input type="checkbox"/> APRN/NP |
| <input type="checkbox"/> LVN/LPN | <input type="checkbox"/> RN |
| <input type="checkbox"/> RN Equivalent (International) | <input type="checkbox"/> None |

Primary Specialty

- | | |
|---|--|
| <input type="checkbox"/> Blood & Marrow Transplantation | <input type="checkbox"/> End-of-Life Care |
| <input type="checkbox"/> Hematology | <input type="checkbox"/> Home Care |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Intensive Care |
| <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> Medical-Surgical Oncology |
| <input type="checkbox"/> Non-Oncology | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Prevention/Detection | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Surgical Oncology | <input type="checkbox"/> Survivorship |
| <input type="checkbox"/> N/A | |

Primary Work Setting

- | | |
|--|---|
| <input type="checkbox"/> Academic Institution | <input type="checkbox"/> Extended Care Facility |
| <input type="checkbox"/> Government Agency | <input type="checkbox"/> Healthcare Industry |
| <input type="checkbox"/> Home Care | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Hospital Setting (Ambulatory) | <input type="checkbox"/> Hospital Setting (Inpatient) |
| <input type="checkbox"/> Physician Practice | <input type="checkbox"/> Professional Association |
| <input type="checkbox"/> Survivorship Clinic | <input type="checkbox"/> Other |

Treatment Area—Select all that apply

- | | |
|--|---|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Head and Neck Cancers |
| <input type="checkbox"/> Gastrointestinal Cancers | <input type="checkbox"/> Genitourinary Cancers |
| <input type="checkbox"/> Gynecologic Cancers | <input type="checkbox"/> Hematologic Malignancies |
| <input type="checkbox"/> Non-Malignant Hematologic Disorders | <input type="checkbox"/> Sarcomas |
| <input type="checkbox"/> Thoracic Cancers | <input type="checkbox"/> Skin Cancers |
| | <input type="checkbox"/> N/A |

What is your primary reason for attending the ONS Congress?

- Gain education/new knowledge
- Earn contact hours for licensure/certification
- Network with my peers
- Present poster or project presentation
- Other (please specify) _____

What are the top three areas in which you need additional information and/or education?

- | | |
|---|--|
| <input type="checkbox"/> Immunooncology | <input type="checkbox"/> Emerging therapies |
| <input type="checkbox"/> Symptom management | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Critical communication | <input type="checkbox"/> Evidence-based practice |
| <input type="checkbox"/> Navigation | <input type="checkbox"/> Oral adherence |
| <input type="checkbox"/> Alternative care delivery models | |

What do you intend to do with the knowledge you gain by attending ONS Congress?

- Make a change in my nursing practice.
- Enhance my institution's current policies and procedures and standards of care.
- Provide my colleagues with information to help improve their clinical practice.

How did you learn about ONS Congress registration?

- | | |
|---|---|
| <input type="checkbox"/> Mailed Postcard/Brochure | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Email | <input type="checkbox"/> Friend/Co-Worker |
| <input type="checkbox"/> Industry Event | <input type="checkbox"/> Supervisor |
| <input type="checkbox"/> Other | |