



REGISTRATION FORM

Please complete and return the registration form, with the appropriate payment or purchase order, on or before **March 9, 2026**. Forms may be returned via email to conferences@nmac.org, or mailed to the address below. For additional information, or to register online, visit www.nmac.org.

2026 Biomedical HIV Prevention Summit (NMAC)
 1050 Connecticut Ave, NW Suite 500
 Washington, DC 20005

Name, Address Organization

Please Note: Be sure to print clearly or type —registration badges are printed only from form entries. Photocopied submissions are okay.

PRINT CLEARLY	Prefix:	First Name:	Last Name:
	Title:		Organization:
	Address:		
	City:	State:	Zip Code:
	Country (if not U.S.):	Telephone:	Fax:
	Email:		

Health Care Provider:

Are you a health care provider?(If yes, please provide the National Provider Identifier (NPI))

National Provider Identifier (NPI) Number:

Demographic Information

This information is used to better serve you and is not required.

Age Range: Under 20 25-34 45-54 65+ 20-24 35-44 55-64	GENDER IDENTITY: Female Male Intersex Non-binary Trans Two Spirit Cisgender Prefer not to disclose Not listed HIV Status: Person Living with HIV Person Living without HIV Unknown Undeclared	Sexual Orientation: Lesbian Bi+ Queer Two Spirit Same Gender Loving Not Listed ETHNICITY <input type="text"/>	Accessibility and Special Needs: Mobility Assistance Sign Language Interpretation n Spanish Translation Vegetarian Vegan No Pork Gluten Free Other (Please list below) _____ _____ _____ _____
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Your Primary Profession / Discipline Training Program:

Advanced practice registered nurse (APRN) (includes nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives)
 Administrative professional (e.g., front desk staff, grant writer, non-clinical management etc.)
 Clergy or faith-based professional
 Community health worker (includes peer educator or navigator)
 Dentist
 Dietitian or Nutritionist
 Nurse Professional (non-prescriber)
 Pharmaceutical Representative
 Psychologist
 Social Worker
 Substance Use Disorder Professional
 Other allied health professional (e.g., medical assistant, physical therapist, etc.)
 Other clinical professional (e.g., podiatrist, chiropractor, etc.)
 Other
 Not Currently Working

Which one of the following best describes your principal employment setting?

- Academic medical/health center
- Correctional institution or other legal system program (e.g., parole, probation, halfway house, etc.)
- Dental health facility
- Emergency department
- Health Center (Federally Qualified Health Center or FQHC)
- Non-FQHC (e.g., HRSA Health Center Program Look-Alike or LAL)
- Health maintenance organization (HMO)/managed care organization
- HIV or infectious diseases clinic
- Hospital
- Indian health services/tribal clinic
- Long-term care facility
- Maternal/child health clinic
- Mental health clinic
- Military or veterans' health facility
- Other community-based organization
- Other federal health facility
- Pharmacy
- Private Practice
- Sexually transmitted infection (STI) clinic
- State or local health department
- Student health clinic
- Substance use treatment center
- University/Institution of higher education
- Other primary care setting
- Primary employment setting does not involve direct provision of care or services
- I am not working

Registration+ Payment

Make all checks, money orders, and purchase orders payable to "NMAC"

REGISTRATION TYPE

Regular

\$400 until March 9, 2026

\$500 On-Site Fee

Federal (For federal employees only, meals are not included)

\$275 until March 9, 2026

\$365 On-Site Fee

Purchase Order:

Attach two copies of the completed purchase order to this Registration Application

PRINT CLEARLY	Payment Type				Total Amount Enclosed
	Check	Money Order	Purchase Order		
	Credit Card				Card Holder's Name (As shown on the card)
	VISA	MC	AMEX	Discover	
	Account Number				CVV#
	Expiration Date				Today's Date
Signature					

Agreement:

By submitting this registration form, the attendee acknowledges and agrees that the confidentiality of the contact and demographic information provided—including, but not limited to, name, mailing address, zip code, telephone number, gender, and HIV status—cannot be guaranteed. Information collected through this form may be used by NMAC for the purposes of program registration, program support administration, and related organizational activities. As part of these processes, such information may be disclosed to NMAC staff, program partners, and corporate sponsors as necessary for the administration, evaluation, and implementation of related programs. By proceeding with this submission, the applicant consents to the collection, use, and limited disclosure of their information as described above.

Sign Here



Authorized Signature: _____ Date: _____