



# WOA's 90th Annual Meeting Registration

July 29-August 1, 2026 • The Broadmoor • Colorado Springs, CO

MAIL: Western Orthopaedic Association, 110 West Rd, Suite 227, Towson, MD 21204

PHONE: 866-962-1388 • FAX: 410-494-0515 • WEB: [www.woa-assn.org](http://www.woa-assn.org)

Name	Degree	Sub-Specialty			
Company/Institute			Department		
Address		City	State	ZIP Code	
Office Phone			Email Address		

**Physician/Allied Health Registration Fee Includes:** Scientific Sessions, Poster Sessions, Symposia, Continental Breakfasts, Workshops, Breaks, Welcome Dinner, Exhibitor Reception, and the Family Gala Dinner.

**Spouse/Guest Registration Fee Includes:** Guest/Child Hospitality on Thursday, Friday and Saturday mornings, Welcome Dinner, Exhibitor Reception, and the Family Gala Dinner.

**Child Registration Fee Includes:** Guest/Child Hospitality on Thursday, Friday and Saturday mornings, Welcome Dinner and the Family Gala Dinner.

#	REGISTRANT CATEGORY	FEE
	New 2026 WOA Physician Member	\$423
	WOA Member Physician	\$845
	Non Member Physician	\$1245
	Non Member Moderator/Presenter	\$845
	Senior Active Member	\$550
	Active Duty Military Physician	\$350
	Allied Health Professional Member	\$300
	Allied Health Professional Non Member	\$650
	Fellow	\$300
	Resident	\$300
	Medical Student	\$300
	Member Spouse/Guest (18+)	\$350
	Non Member Spouse/Guest (18+)	\$450
	Resident/Fellow/Student Spouse/Guest (18+)	\$225
	Child(ren) 5-17 years	\$65
	Child(ren) under 5 years	No Charge

Please provide the information below for each of your **adult** guests so we can put their name badges in your registration packet. Registered children (5-17) will receive a wristband.

Guest Name	City	State
Guest Name	City	State
Guest Name	City	State
Guest Name	City	State

**CANCELLATION POLICY:** Full refund (less \$50 administrative fee) will be granted if a cancellation is made prior to 10 business days before the meeting date; a 50% refund if canceled between 5 and 10 business days before the meeting date. No refund will be granted within 5 business days of the meeting, or anytime thereafter.

☐ **SPECIAL NEEDS:** If you have hearing, vision or mobility impairment and need appropriate accommodations in order to participate fully in this activity, please notify us by July 1, 2026. You will be contacted by the WOA Management Company, DTMS, to discuss your needs.

- ☐ I would like to opt out of receiving promotional emails.
- ☐ Do not share my information with third party vendors.

## Make Memories at The Broadmoor

Choose adventures tailored to your taste - for details and to book activities, scan the QR code or visit:



<https://www.broadmoor.com/adventures>

**Tour/Activity Ticket Cancellation Policy:** Full refund will be granted if a cancellation is made prior to 30 business days before the meeting date. No refund will be guaranteed within 30 business days of the meeting. WOA will attempt to sell unwanted tickets on a first-come, first-serve basis. If WOA sells your unwanted ticket, you will receive a full refund of the ticket cost. WOA reserves the right to cancel an activity if the minimum number of participants has not purchased tickets prior to 30 business days before the meeting date.

#	ACTIVITIES	FEE
	Golf Tournament - (\$315 per person) - Friday	

ONLY **unregistered** guests, and children who wish to attend events should fill out the Events form below. These events are **included** for registered guests and children.

#	UNREGISTERED GUEST EVENTS	FEE
	Thursday Guest/Child Hospitality - Adult (\$60)	
	Thursday Guest/Child Hospitality - Child 5-17 (\$40)	
	Welcome Dinner - Adult (\$100)	
	Welcome Dinner - Child 5-17 (\$50)	
	Friday Guest/Child Hospitality - Adult (\$60)	
	Friday Guest/Child Hospitality - Child 5-17 (\$40)	
	Exhibitor Reception - Adult (\$75)	
	Saturday Guest/Child Hospitality - Adult (\$60)	
	Saturday Guest/Child Hospitality - Child 5-17 (\$40)	
	Family Gala Dinner - Adult (\$150)	
	Family Gala Dinner - Child 5-17 (\$75)	

Physician/Allied Health Registration Fee \$ \_\_\_\_\_

Guest Registration Fees \$ \_\_\_\_\_

Tours/Activities Fees \$ \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

- ☐ Check Enclosed (payable to Western Orthopaedic Association)
- ☐ Charge my: ☐ Visa ☐ MasterCard ☐ American Express

CARD NUMBER EXP. DATE CVV

NAME ON CARD

BILLING ADDRESS

CITY STATE ZIP CODE