# Connecticut Society of Eye Physicians

## Annual Education Program

**Date of Event _____**

## Credit Card Payment Form

**Fax to 860-567-3591 or Email debbieosborn36@yahoo.com**

_____Visa _____ Mastercard _____ American Express

____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /

(16 digit card number)

____ /____ /____

(Expiration date)

____ /____ /____

*3 digit # that appears on the back of the Visa/Mastercard

____ /____ /____ /____

*4 digit # that appears on the front of the American Express

**Please print company name and Email address of who payment is being made**

Company name_____ email address _____

| Name of Representative Attending | Email address of Attendee |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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$ _____ Total amount charged

_____ (Card holder's name)

_____ (Card holder's signature)

_____ (Card holder's address - where statement is mailed)

_____ (Practice name)

_____ (City - State)

5 digit Zip code (required) _____

_____ Email address

CSEP, 26 Sally Burr Road • P.O. Box 854 • Litchfield, CT 06759

Please fill out completely! *These numbers are required