Connecticut Society of Eye Physicians

Annual Education Program

Friday, June 10, 2016

The Aqua Turf Club

556 Mulberry Street, Plantsville, CT

Registration Summary Form

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

#_____ M.D. ***120.00 pre-registered, $150.00 member registers at event**

#_____ Residents - Complimentary
*Note: Per direction of the Executive Committee, attendance at CSEP sponsored educational physician meetings is limited to M.D.s only

#_____ Administrator or billing Staff $120.00

#_____ Technicians $100.00

* If you or your employer are not CSEP members, or state ophthalmologic society members add $100 to each registration.

Physician's Name _____

Address _____

Email Address _____

Employee Name _____

Physician's Name where employed _____

Address _____

Email Address _____

Please include a separate piece of paper listing all attendees if more than one with this form

Total number of Physicians attending _____ x $120.00 = $_____

Total number of Technicians attending _____ x $100.00 = $_____

Total number of Managers/billing staff _____ x $120.00 = $_____

Total Amount $_____

Please mail this form with your payment to: CSEP, P.O. Box 854, Litchfield, CT 06759

FAX: 860-567-3591 with enclosed credit card form

You can scan this form and email with credit card information to debbieosborn36@yahoo.com

Deadline for Pre-Registration is May 20, 2016

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

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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

Names of Attendees

_____ Physicians Attending _____Technicians Attending _____Administrators Attending

_____ _____

_____ _____

_____ _____

_____ _____

$ _____ Total amount charged

_____ _____

(Card holder's name) (Card holder's signature)

_____ _____

(Card holder's address) (Practice name)

_____ 5 digit Zipcode (required) _____

(City - State)

_____ Email address

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Please fill out completely! *These numbers are required