Connecticut Society of Eye Physicians
2014 DUES STATEMENT
January 1, 2014 thru December 31, 2014

Physician Member's Name _____ Email _____

Practice Name _____

Annual Membership Dues	$750.00
Member 1st Year in Practice	$375.00
Residents	Exempt
Members over 65	Exempt, who are fully retired and have been a member for three consecutive years.
Members over 65, who are part-time	$375.00

Discounts:

1. **10% Early Bird Discount** ($75.00) if payment is received by **December 31, 2013.**
2. **10% Group** (if **all** members of your group are members only - please pay for all members at the same time to avoid losing the discount) or if you are a solo practice or partnership and you have been a consecutive member for the last three years take a 10% discount. ($75.00 per member).

Computation for dues:

$750.00 x _____# of members	$_____
Less discounts that apply:	
10% Early Bird Discount	
$75.00 per member x _____# of members	$_____
10% group or 3 year solo members	
$75.00 per member x _____# of members	$_____
Total Dues after Discounts	$_____

Please note that if you take advantage of both discounts, your dues per member will be reduced to: $600.00.

Any payments for dues received after December 31, 2013 will be $675.00. No exceptions.

We appreciate your continued support and look forward to working on your behalf in 2014.
Please note that this year we are accepting payments by check, MasterCard, Visa or American Express.
For credit card payments please fax back the attached form.

Thank you!

P.O. Box 854, 26 Sally Burr Road, Litchfield, CT 06759
Tel. (860) 567-3787 Fax (860) 567-3591
email: debbieosborn36@yahoo.com
www.connecticutsocietyofeyephysicians.com

CSEP DUES

PO BOX 854, LITCHFIELD, CT 06759

This portion can be faxed back to (860) 567-3591 or Email debbieosborne36@yahoo.com
for your 2014 CSEP dues using a credit card

_____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

$_____ (amount of dues based on dues statement worksheet x _____ # of physicians)

$_____ Total amount charged

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

_____ _____
(Card holder's address where statement is mailed) (Group Practice name)

_____
(City - State - Zip)

Please print names of M.D.s being paid for:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Personal checks can be mailed to: CSEP, 26 Sally Burr Road • PO Box 854 • Litchfield, CT 06759

"M.D. Makes the Difference"