



Connecticut Society of Eye Physicians

Semi-Annual Education Program

Friday, January 13, 2017

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 Administrator/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 December 31, 2016

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



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Annual Education Program

Credit Card Payment Form

Fax to 860-567-3591 or Email debbiesborn36@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)

_____ (City - State)

5 digit Zipcode (required) _____

_____ Email address