REGISTRATION FORM
CSEP PHYSICIAN PROGRAM (Ophthalmologists only)
Friday, June 14, 2013
Connecticut Society of Eye Physicians Annual Educational Program
The Aqua Turf Club, 556 Mulberry Street, Plantsville, Connecticut

Please make the following reservations:

#___CSEP members at **$120.00 pre-registered, $150.00 member registers at event**

#___Non-CSEP ophthalmologists at **$200.00 pre-registered, $230.00 member registers at event**

#____Residents - Complimentary
*Note: Per direction of the Executive Committee, attendance at CSEP sponsored educational meetings is limited to physicians, or out of state physicians who are members of their state society, and ophthalmology residents and fellows.

(NOTE: Do NOT use this form to register for the separate meetings for ophthalmic management or ophthalmic technicians.)

____
Name (print) Address Telephone

____
Email Address

The Connecticut Society of Eye Physicians is accredited by the Connecticut State Medical Society to sponsor continuing Medical Education for Physicians.

My check for $_____________is enclosed.

Please mail your check and reservation to:
CSEP, P.O. Box 854, Litchfield, CT 06759 or FAX: 860-567-3591

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(for CSEP office use only)

Check #_______________ Amount:___________________ Received:__________________

DEADLINE FOR REGISTRATION IS June 4, 2013

The Connecticut Society of Eye Physicians designates this educational activity for a maximum of 7.0 AMA PRA Category I Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AMA PRA Category I Credit is a trademark of the American Medical Association. Accredited providers are required to use "AMA PRA Category I Credit™ whenever the complete phrase is first used in any publication, and periodically through the publication. This standard language, along with the Designation Statement, benefits both providers and physicians by clearly communicating the provider's privilege to award AMA PRA Category I Credit on behalf of the AMA.

REGISTRATION FORM

CSEP Management Program

Friday, June 14, 2013

Connecticut Society of Eye Physicians Annual Educational Program

The Aqua Turf Club, 556 Mulberry Street, Plantsville, Connecticut

NAME:____
(Please print)
ADDRESS:____
(Please print)
CITY:____STATE:________ZIP:________

TELEPHONE:____

EMAIL ADDRESS:____

NAME OF PHYSICIAN MEMBER WHERE EMPLOYED (not practice name):

____

FEES

$145.00 - Affiliated	**$250.00 - Non-Affiliated**
(Employed by a physician who is a CSEP member)	(Employed by a physician who is not a CSEP member)

Please mail this form with your payment to:

CSEP, P.O. Box 854, Litchfield, CT 06759 FAX: 860-567-3591 email-debbieosborn36@yahoo.com

(This form may be copied for additional registrations)

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(for CSEP office use only)

Check #____________________ Received:__________________ Amount:_____________

Please note: Space is limited to the first 100 registrants

REGISTRATION FORM

CSEP TECHNICIANS PROGRAM

Friday June 14, 2013

Connecticut Society of Eye Physicians Annual Educational Program

The Aqua Turf Club, 556 Mulberry Street, Plantsville, Connecticut

NAME:____
(Please print)

ADDRESS:____
(Please print)

CITY:______________________________________STATE:________ZIP:________

TELEPHONE:____

EMAIL ADDRESS____

NAME OF PHYSICIAN MEMBER WHERE EMPLOYED (not practice name):

____

FEES

$100.00 - Affiliated
(Employed by a physician who is a CSEP member)

$150.00 - Non-Affiliated
(Employed by a physician who is not a CSEP member)

Please mail this form with your payment to:

CSEP, P.O. Box 854, Litchfield, CT 06759 FAX: 860-567-3591

(This form may be copied for additional registrations)

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(for CSEP office use only)

Check #____________________ Received:__________________ Amount:___________

DEADLINE FOR REGISTRATION IS June 4, 2013

Please Note: Space is limited to the first 175 registrants

This course has been submitted to JCAHPO for 6.50 JCAHPO CE Credits

Connecticut Society of Eye Physicians
Annual Education Program
June 14, 2013
Credit Card Payment Form

PO BOX 854, LITCHFIELD, CT 06759
This portion can be faxed back to (860) 567-3591

________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____________
(City - State)

____Email address

CSEP, 26 Sally Burr Road • PO Box 854 • Litchfield, CT 06759

Please fill out completely!
*These numbers are required