CONTINUING EDUCATION COMPANY

25th ANNUAL PRIMARY CARE CONFERENCE I
June 26-30, 2017/ Kiawah Island Golf Resort/ Kiawah Island, SC

Registration Form (FAX: TO 516-539-3555)

FIRST NAME: _____

LAST NAME: _____

ATTENDEE'S EMAIL: _____

ADMINISTRATOR'S EMAIL: _____

PRACTICE/ORGANIZATION NAME: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

ADDRESS: _____

CITY: _____ **STATE/PROVINCE:** _____ **POSTAL CODE:** _____

COUNTRY: _____

Specialty: _____

Years Practicing: _____ **Title: MD/DO/NP/PA/Other:**_____

Patient Population: ___General (all ages/both genders) ___Children __Young Adults/ Adolescents

___Adult Men & Women ___Adult Men ___Adult Women ___Elderly ___Other_____

How did you hear about this conference: _____

Do you practice in a rural area? ___Yes ___No

Fees:

24th Annual Primary Care Conference

☐ $695.00 - Physicians ☐ $610.00 - Residents and other healthcare professionals

PAYMENT METHOD:

___Credit Card (VISA or MASTERCARD ONLY)

Card Number: _____

Name on Card: _____

Expiration Date: _____ Security # (on back of card): _____

Billing Address (If different from above): _____

___Check (Make payable to *Continuing Education Company, Inc.*

Mail to: Continuing Education Company, Inc.
250 Palm Coast Pkwy NE, Suite #607 - 152, Palm Coast, FL 32137-8224

CONTINUING EDUCATION COMPANY

25th ANNUAL PRIMARY CARE CONFERENCE II
July 3-7, 2017/ Kiawah Island Golf Resort/ Kiawah Island, SC

Registration Form (FAX: TO 516-539-3555)

FIRST NAME: _____

LAST NAME: _____

ATTENDEE'S EMAIL: _____

ADMINISTRATOR'S EMAIL: _____

PRACTICE/ORGANIZATION NAME: _____

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WORK PHONE: _____

CELL PHONE: _____

ADDRESS: _____

CITY: _____ **STATE/PROVINCE:** _____ **POSTAL CODE:** _____

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