

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

TUITION:	___ \$695.00	Physician
	___ \$610.00	Residents, NP, PA and other allied 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.

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