

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: ☐ \$695.00 - Physicians ☐ \$610.00 - Residents and other healthcare professionals ___\$100.00 - Conference Recording

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