

58TH ANNUAL POST-GRADUATE REVIEW COURSE

Ophthalmology CME Attendees

Course: Nov. 30-Dec. 1, 2007 Registration deadline: Nov. 23, 2007

Mail to: Ophthalmology Review Course, Department of Ophthalmology, SUNY Upstate Medical University, 550 Harrison Street, Suite 340, Syracuse, NY, 13202.

Please print.

Name Degree Specialty

Institution / Private Office Name

Address: Home Work

City State Zip

E-mail Address (for registration confirmation)

Telephone: Home Work Last 4 Digits Social Security Number (for record-keeping)

If special accommodations or dietary restrictions are required, please specify:

FRIDAY EVENT Dinner with guest faculty at the Genesee Grande Hotel

Space is limited; reservations are required and are accepted on a first come, prepaid basis. The fee is \$48 per person. If you would like to attend please indicate your dinner choice. (Dinner reservations are non-refundable.) Dinner reservations and payment must be received by Nov. 23.

Persons _____ @ \$48 each = \$ _____ Total

Choice of Entrée: Prime Rib Salmon Vegetarian

FRIDAY SPOUSE/GUEST EVENT

The event will be a morning of shopping and lunch at the Carousel Mall. Participants will meet on Friday morning, November 30 at 9:15 am for coffee and danish in the Course Reception area of the Oncenter.

Yes, my spouse/guest plans to participate in shopping and lunch

Spouse/Guest Name: _____

PAYMENT

Practicing Physician\$245

Fully-Retired Physician\$125

Physicians over Age 70\$125

Resident-in-Training\$125

(Resident registrations must be submitted through their department)

Nurses\$95

Please indicate method of payment (include Friday dinner if applicable.)

Total payment enclosed \$ _____

Check payable to SUNY Upstate Ophthalmology VISA MasterCard

Credit Card Number Exp. Date

Name as it appears on card (please print)

Cardholder's signature

JCAHPO REGIONAL EDUCATION PROGRAM

Ophthalmology JCAHPO Participants

Course: Nov. 30, 2007 Registration deadline: Nov. 23, 2007

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Please print.

Name Professional Credentials

JCAHPO ID# / ATPO Member # Date of Birth mm/dd/yy

Home Address

City State Zip

Practice / Business Name

Work Address State Zip

E-mail Address (for registration confirmation)

Home Telephone Work Telephone

Person to Notify in Case of Emergency (name and phone number)

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JCAHPO Certified, ATPO or CLAO members\$95

Please indicate method of payment (include Friday dinner if applicable.)

Total payment enclosed \$ _____

Check payable to SUNY Upstate Ophthalmology

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