



REGISTRATION FORM

Clinic/Practice _____

Address _____

City _____

State _____

Zip _____

TECHS

#1

Name _____

COA COT COMT RN Other _____

Email _____

#2

Name _____

COA COT COMT RN Other _____

Email _____

#3

Name _____

COA COT COMT RN Other _____

Email _____

#4

Name _____

COA COT COMT RN Other _____

Email _____

#5

Name _____

COA COT COMT RN Other _____

Email _____

REGISTRATION

Qty	Registration Type	Total
	Early Bird Rate - \$250 (before 2/15/19)	
	Registration - \$300 (after 2/15/19)	
		Total Due \$

PAYMENT INFORMATION

Register Online at www.oregoneyephysicians.org, or fax or mail this form with payment information.

Name on Card _____

Card Number _____

Expiration Date _____

CVV _____

Email for Receipt _____

Signature _____

Oregon Academy of Ophthalmology

8 N State Street, Ste 200 | Lake Oswego, OR 97034 | 503-303-5071 | Fax 503-210-1533
www.oregoneyephysicians.org | staff@oregoneyephysicians.org

CANCELLATION POLICY: \$50 administrative service charge for cancellations