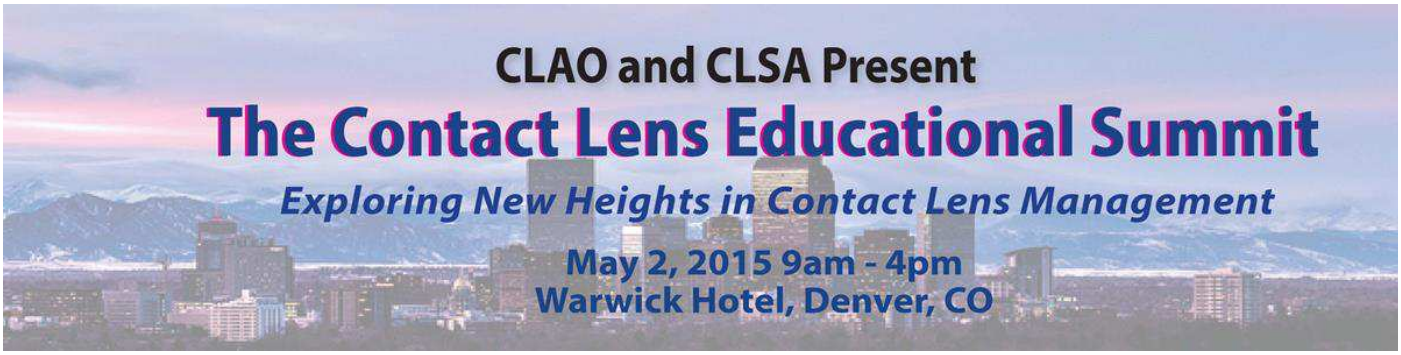

Registration Form

☐ Non-Member	$249.00	QTY___	☐ Faculty	$ 99.00	QTY___
☐ CLAO Member	$199.00	QTY___	☐ Resident/Fellow/Nurse	$ 59.00	QTY___
☐ CLSA Member	$149.00	QTY___	☐ Spouse/ Guest	$ 50.00	QTY___

Total: $_____

Attendee Name(s) (Please include any Credentials to be included on Name Badge):

_____

_____

Employer (if applicable):_____

Address:_____

Phone:_____

Email:_____

☐ Yes, I will be attending the Myopia Symposium, immediately following the Summit (Free) 4- 6pm

Attendee Name(s) (If different than below):_____

PAYMENT OPTIONS

☐ I have enclosed a Check in the Amount of $_____

☐ Please charge my credit card for the Above Amount ☐ Visa ☐ MasterCard ☐ Discover ☐AMEX

CARD # _____ EXPIRATION DATE: _____
(*Be sure to enter the complete card number.)*

SECURITY CODE (3 -digit # on back of card OR 4-digit # on front of card): _____

CARDHOLDER NAME - PRINTED: _____

CARDHOLDER ADDRESS:_____

CARDHOLDER ZIP/POSTAL CODE: _____

CARDHOLDER SIGNATURE: _____

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1-800-296-9776 ● bhahn@clsa.info