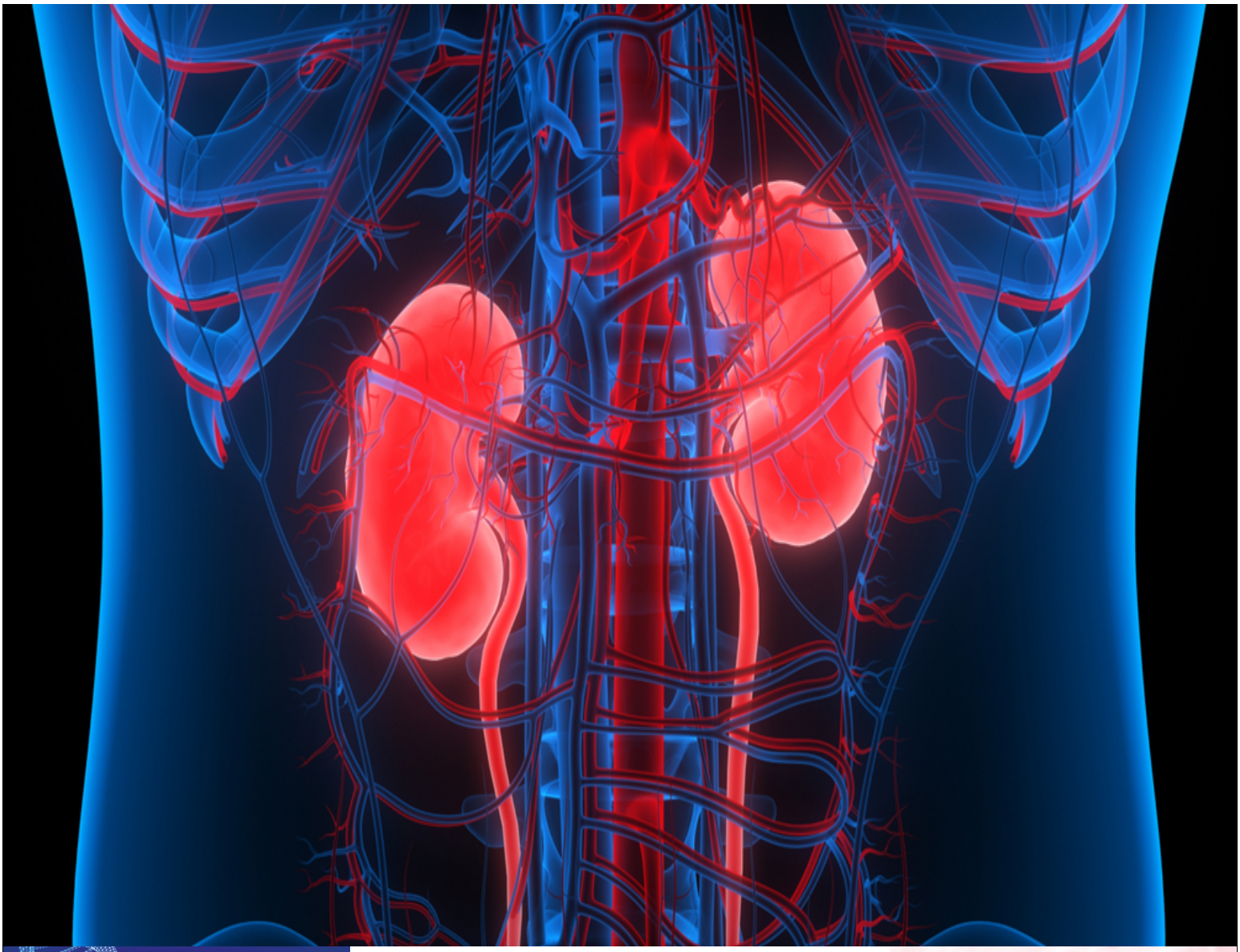
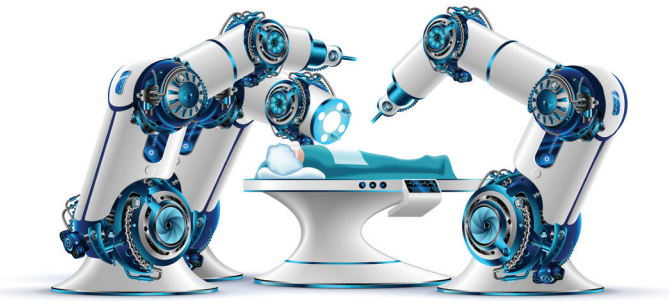
Connecticut Urology Society
November 13, 2024
Annual Scientific Program

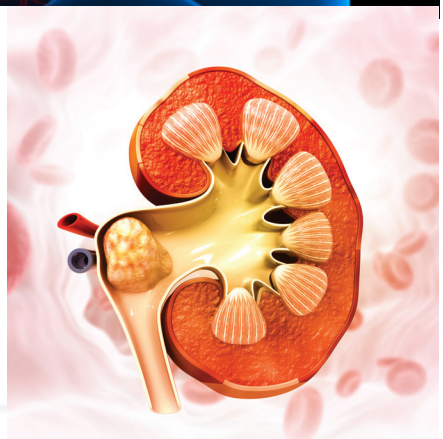
8:00am- 4:00pm

Aqua Turf Club 556 Mulberry Street, Plantsville, CT 06479

Connecticut Urology Society







The Connecticut Urology Society Annual Meeting

Wednesday November 13, 2024

Program

Email: debbieosborn36@yahoo.com Cell: 860-459-4377

Registration Form

NAME:_____
(please print)

ADDRESS:_____
(please print)

CITY:_____STATE:_____ ZIP:_____

TELEPHONE:_____

EMAIL ADDRESS:_____

_____ Yes, I am planning on attending the November 13, 2024 Education Program

_____ No, I am unable to attend the November 13 2024 Education Program

Early Bird Member Physician Fee: $100.00 if paid by October 1, 2024

Member Physician Fee:	**$125.00 *After October 1, 2024***
Non-Member Fee:	**$200.00 if paid by October 1, 2024** **$225.00 *After October 1, 2024***
Non-M.D (ie. PAs, APRNs)	**$ 75.00**
Residents:	**Complimentary**

Please mail or fax this form to:
CT Urology Society, P.O. Box 854, Litchfield, CT 06759 Fax: 860-5674174

This activity has been planned and implemented in accordance with the Essentials and Standards of ACCME through the joint sponsorship of CSEP and The Connecticut Urology Society. CSEP is accredited by ACCME to provide continuing medical education for physicians.

CSEP designates this educational activity for a maximum of TBA credit hours in category I credit toward the AMA Physicians Recognition Award. Each physician should claim only those hours of credit that he/she spent in the activity.

(Please use a separate form for each physician)

****

PLEASE NOTE!

PAYMENT WILL BE THROUGH THE CONNECTICUT SOCIETY OF EYE PHYSICIANS.

Connecticut Urology Society
Credit Card Payment Form
Annual Scientific Education Program

This portion can be faxed back to (860) 496-1830 or Email debbieosborn36@yahoo.com

_____Visa _____Mastercard _____American Express

____/____/____/____/____/____/____/____/____/____/____/____/____/____/____/____
(16 digit card number)
_____/_____/_____
(Expiration date)

Security Codes

____/____/____
*3 digit # that appears on the back of the MC/VISA card

_____/_____/_____/_____
4 digit # that appears on the front of AMEX card

Name of Attendee _____ _____

Email _____ _____

Cell phone _____ _____

Payment included: $ _____

_____ _____
(Card holders name) (Card holders signature)

_____ _____
(Card holders address) (Group Practice name)

*_____
(City - State - Zip) Need Zip code from card billing address to process

"M.D. Makes the Difference"

Please fill out completely!

These numbers are needed to run payment through with a merchant discount