Connecticut Urology Society

The Connecticut Urology Society Annual Meeting

Thursday October 23, 2025

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 October 23, 2025 Education Program

_____ No, I am unable to attend the October 23, 2025 Education Program

Early Bird Member Physician Fee: $100.00 if paid by October 1, 2025

Member Physician Fee:	**$125.00** ***After October 1, 2025***
Non-Member Fee:	**$200.00 if paid by October 1, 2025** **$225.00** ***After October 1, 2025***
Non-M.D (ie. PAs, APRNs)	**$ 75.00**
Residents:	**Complimentary**

Please mail or fax this form to:
CT Urology Society, P.O. Box 854, Litchfield, CT 06759 Fax: 860-567-4174

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

CSEP designates this educational activity for a maximum of 5.0 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) 567-4174 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