

GROUP REGISTRATION FORM



NEW DATES! May 8-14
Grand Wailea Maui

Physician Contact Information: **Comprehensive Program** **Retina Program**

First Name _____ Last Name _____ Suffix _____ Degree _____

Address _____

City _____ State _____ Postal Code _____ Country _____ Phone _____

Email (for confirmation, hotel and CME evaluation purposes) _____ Year of Medical School Graduation _____

<p>Profession:</p> <p><input type="checkbox"/> Physician <input type="checkbox"/> Resident</p> <p><input type="checkbox"/> Physician Assistant <input type="checkbox"/> Other: _____</p>	<p>Primary Specialty:</p> <p><input type="checkbox"/> Ophthalmology</p> <p><input type="checkbox"/> Other: _____</p>	<p>Subspecialty/Area of Interest:</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Cataract surgery</td> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Pediatrics/Strabismus</td> </tr> <tr> <td><input type="checkbox"/> Contact lenses</td> <td><input type="checkbox"/> Neurosciences</td> <td><input type="checkbox"/> Refractive surgery</td> </tr> <tr> <td><input type="checkbox"/> Cornea/External disease</td> <td><input type="checkbox"/> Oculoplastics</td> <td><input type="checkbox"/> Retina/Vitreous sciences</td> </tr> <tr> <td><input type="checkbox"/> General ophthalmology</td> <td><input type="checkbox"/> Optics</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> Cataract surgery	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pediatrics/Strabismus	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Neurosciences	<input type="checkbox"/> Refractive surgery	<input type="checkbox"/> Cornea/External disease	<input type="checkbox"/> Oculoplastics	<input type="checkbox"/> Retina/Vitreous sciences	<input type="checkbox"/> General ophthalmology	<input type="checkbox"/> Optics	<input type="checkbox"/> Other: _____
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You must provide a name and unique email for each nurse/administrator attendee:

Name	Email	Program (circle one)
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator
_____	_____	Nurse / Administrator

REGISTRATION	PAYMENT
<p>Groups of 3+ save \$450 per nurse or administrator! <i>One physician must register with the group.</i></p> <p>_____ Total Number of Physicians <input type="checkbox"/> US \$1,630 + Hawaii Excise Tax = \$1,697.92 (extended to 5/3/21)</p> <p>_____ Total Number of Nurses or Administrators <input type="checkbox"/> US \$615 + Hawaii Excise Tax = \$640.63</p> <p>TOTAL \$ _____</p>	<p>Please send this form and call us with payment information:</p> <p>Meeting Registration 1-877-307-5225 x219/x476 (Monday-Friday, 9-5 ET)</p> <p>Fax this form to: 856-251-0278</p> <p>Email this form to: registration@HealioLive.com</p>
<p>Meeting Cancellation: Without any penalties, you may cancel your registration through April 26, 2021 (request in writing to registration@HealioLive.com) and room reservation up until 14 days prior to your arrival. Should the meeting need to be canceled altogether, you'll receive a 100% refund on your registration fee and room deposit.</p> <p>Hotel Reservations: The meeting cannot guarantee room availability or room type. Please make sure each attendees' email is filled out and legible on this form.</p> <p>ADA Compliance: We will make all reasonable efforts to accommodate persons with disabilities if your request is made at least 30 days in advance by calling 856-848-1712 ext. 219 or ext. 476.</p>	
<p>Federal ID #: 27-4318741</p>	