

DMEK

For experienced DSEK/DSAEK surgeons

2010 Registration Form



NAME (for Name Badge):	
NAME (for Certificate):	
PRACTICE NAME:	
STREET ADDRESS:	
CITY, STATE, ZIP CODE:	
COUNTRY:	
TELEPHONE NUMBER:	
CELL PHONE NUMBER: For use only if needed during the course.	
E-MAIL: Participant	
E-MAIL: Assistant or Administrator	
DIETARY RESTRICTIONS:	

All dates are Tuesday/Wednesday

_____ February 9, 2010	_____ August 17, 2010
_____ April 15, 2010	_____ September 14, 2010
_____ May 11, 2010	_____ December 14, 2010

\$750
nurse with
registered physician.

Registration Fee: U.S. \$2,400

Type of Card:	Visa / MasterCard only	Security Code:
Credit Card Number:		
Name on Card:		
Expiration Date:		Billing Zip Code:

1-5-10

Fax or email this completed form as soon as possible to tentatively hold your reservation. *Please do not finalize your travel arrangements until you receive notification that your course reservation is confirmed.*

Payment is required in advance. Please provide credit card information above, or mail your check, payable to Price Vision Group to:

Wendy Mickler
Price Vision Group • 9002 North Meridian Street, Suite 100 • Indianapolis, IN 46260
(Tel) 317-814-2823 • (Fax) 317-844-5590 • wendymickler@pricevisiongroup.net