REGISTRATION FORM FOR CPG COURSE/WORKSHOP

Please fax to: 727 341-0121 or e-mail to: ao@baymedical.com

COURSE DATE REQUESTED .....(PLEASE PRINT)
LOCATION.....

LAST NAME _____ FIRST NAME_____

DEGREE(S): M. D. ..... D.O. ..... OTHER .....
ACADEMIC TITLE:.....

RESIDENCY PROGRAM:
INSTITUTION..... YEAR OF GRADUATION .....

THE AMERICAN BOARD of Ob/Gyn ELIGIBLE..... YEAR.....
THE AMERICAN BOARD DIPLOMAT IN Ob/Gyn ..... YEAR.....
Other Board Certified.....Year.....
THE FOREIGN SPECIALIST IN..... YEAR.....

TYPE OF PRACTICE.....Since.....
ADDRESS.....
PHONE ..... E-MAIL ADDRESS.....
FAX ..... WEBSITE ADDRESS .....
PRACTICE
ADDRESS.....
CONTACT INFORMATION.....

For more information, please call: (727) 458 6060 6606 or e-mail to:ao@baymedical.com

PRINT YOUR NAME.....

SIGNATURE.....

TUITION FEE for 3-Day COURSE/WORKSHOP
is

$ 8,000 (eight thousand)

INDIVIDUAL 3-Day One-on-One Course/Workshop is Available, tuition fee will be DETERMINED)

PROKTORSHIP is Available in Your Place (OR), tuition fee will be DETERMINED

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You can make a payment by:

Certified bank check,

Credit card (see payment authorization form below),

Wire payment (bank information will be sent upon request).

Make check payable to: Institute of Gynecology

Mail to:

7001 Central Ave.
St. Petersburg, FL 33710, U.S.A.

CREDIT CARD AUTHORIZATION FORM (Please fax THE FORM back to: (727) 341-0121 or e-mail to: ao@baymedical.com)

CRRDIT CARD AUTHORIZATION

I _____ AUTHORIZE MY CREDIT CARD LISTED BELOW TO BE CHARGED FOR _____

CREDIT CAR TYPE:

_____ VISA

_____ AMERICAN EXPRESS

_____ MASTERCARD

_____ DISCOVER CARD

CREDIT CARD NUMBER _____ PIN NO._____

EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CARD _____

AUTHORIZED SIGNATURE _____

TELEPHONE NUMBER ( )_____

ATTACH A LEGIBLE COPY OF THE FRONT & BACK THE YOUR CREDIT CARD.

Contact: Institute of Gynecology

call mobile: (727) 458-6060 or

e-mail to: ao@baymedical.com, if you need assistance.