



A JOINT MEETING
CLINICAL ORTHOPAEDIC SOCIETY
COLORADO ORTHOPAEDIC SOCIETY



MEETING REGISTRATION FORM

If paying by check, please make check payable to **COS** and mail to: 2209 Dickens Road, Richmond, VA 23230-2005; Phone: (804) 565-6366; Fax: (804) 282-0090

PLEASE PRINT OR TYPE

Name _____ MD PhD DO
 _____ CRNA Other: _____
 Last First MI
 Preferred Mailing Address _____
 City / State / Zip _____ Email Address _____
 Office Phone _____ Home Phone _____ Fax _____

Registration Policy: All attendees including spouse/guest must pay a registration fee to attend any COS event unless otherwise noted below. Badges are required for entrance to all scientific sessions and social functions. Registration fees include: Welcome Reception, Physician and spouse/guest breakfast and breaks. **Plus Live Patient Case Presentations.** All fees help to cover meeting expenses. Please complete all areas on this form. All fees are per person.

Check all that apply	After 8/9/10	
<input type="checkbox"/> Clinical Orthopaedic Society Member	\$675	= \$ _____
<input type="checkbox"/> Colorado Orthopaedic Society Member	\$675	= \$ _____
<input type="checkbox"/> Non-Member - US & Canada	\$775	= \$ _____
<input type="checkbox"/> One day registration <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	\$275	= \$ _____
<input type="checkbox"/> Emeritus	\$295	= \$ _____
<input type="checkbox"/> First Year Member	\$295	= \$ _____
<input type="checkbox"/> Candidate Member	\$295	= \$ _____
<input type="checkbox"/> Physician Assistant	\$595	= \$ _____
<input type="checkbox"/> Orthopaedic Resident*	Fee waived	= \$ _____
<input type="checkbox"/> Spouse/Guest(s) # _____	\$100 each	= \$ _____
Name: _____	E-Mail: _____	

Fee includes Welcome Reception & three Continental Breakfasts

Colorado Rockies tickets (vs. San Francisco Giants, Friday, Sept. 24, 6:10 pm) **LIMITED!** Infield box seats @\$47 per ticket. No. of tickets _____ = \$ _____
 I plan to attend the Welcome Reception

* When accompanied by a letter from department chair, verifying resident status.

TOTAL = \$ _____

Please Send Payment to:
Clinical Orthopaedic Society, 2209 Dickens Road, Richmond, VA 23230-2005

(Credit Card payments may be faxed to 804-282-0090)

- Personal Check VISA MasterCard American Express

Card No. _____ Exp. Date _____

Signature _____ Printed Name on Card _____

Refund Policy: 50% refund through 8/9/2010; no refunds after 8/9/2010. Refund will be determined by date *written* cancellation is received.

If you do not receive a confirmation letter from the COS within 30 days of submitting your registration, please call the office at 804-565-6366 or email: cos@societyhq.com to confirm that your registration material has been received.