



MEETING REGISTRATION FORM

CLINICAL ORTHOPAEDIC SOCIETY ILLINOIS ASSOCIATION OF ORTHOPAEDIC SURGEONS

100TH ANNIVERSARY MEETING SEPTEMBER 13 - 15, 2012 • CHICAGO, IL

PLEASE PRINT OR TYPE

Name _____
Last First MI

MD PhD DO
 CRNA Other:

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.

*E-Mail required for registration confirmation.

Check all that apply	1/1/12 Through 8/10/12	After 8/10/12	
<input type="checkbox"/> Clinical Orthopaedic Society Member	\$675	\$775	= \$ _____
<input type="checkbox"/> IL Registrants - IAOS Member	\$675	\$775	= \$ _____
<input type="checkbox"/> Non-Member - US & Canada	\$775	\$875	= \$ _____
<input type="checkbox"/> Emeritus	\$320	\$345	= \$ _____
<input type="checkbox"/> First Year/Candidate Member	\$320	\$345	= \$ _____
<input type="checkbox"/> Physician Assistant	\$595	\$695	= \$ _____
<input type="checkbox"/> Orthopaedic Resident*	Fee waived	Fee waived	= \$ _____
<input type="checkbox"/> 100th Anniversary Gala (Friday Night) # of tickets _____	\$125 each	\$125 each	= \$ _____
<input type="checkbox"/> Spouse/Guest(s), Morning Hospitality (includes 3 Breakfasts & President's Reception) # of tickets _____	\$75 each	\$75 each	= \$ _____
Name: _____	E-Mail: _____		

* 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. If paying by check, please make check payable to COS.

- Personal Check
 VISA
 MasterCard
 Discover
 American Express

Card No. _____ Exp. Date _____

Signature _____ Printed Name on Card _____

CVV Security Code _____ (3-digit # in signature box on the back of VISA, MC, or Discover or 4-digit # on front of AMEX card above the card #.)

Card Billing Address _____ Card Billing Zip _____

Refund Policy: 50% refund through 8/31/12; no refunds after 8/31/12. 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.