

Registration Form - Histologic Basis of Ocular Disease

Histologic Basis of Ocular Disease June 12 - 15, 2008

Course Fee: **\$575** (plus room and board)

Name: _____

License # (US Residents only): _____

Mailing Address: _____

street

city/state/zip/country

Phone: (_____) _____ FAX #: (_____) _____

Name of Practice/Clinic: _____

E-mail address: _____

Register by Phone, FAX, Mail or On-Line

Histologic Basis of Ocular Disease June 22 - 25, 2006

Course Fee: **\$575** (plus room and board)



Phone: Karl Olson (608) 265-5206
(Credit card information required)



On-Line: www.vetmed.wisc.edu/ce
(Credit card information required)




Fax: Karl Olson (608) 890-1774
(Credit card information required)



Mail: School of Veterinary Medicine
Continuing Education
2015 Linden Dr.
Madison, WI 53706-1102

Payment Method:

Check enclosed (payable to: SVM)

Card #: _____ Cardholder Name: _____

Exp. Date: _____ V-Code: _____ (3 digit number on back of card above signature line)

Amount to be Charged: \$ _____ **\$500 Deposit due by 1/1/08, Balance due by 2/1/08**

I give permission to charge this credit card the balance due of: \$ _____ on _____ (date).

Signature: _____ Date: _____