

# ACE 2020 Registration Form

IJCAHPO's 48<sup>th</sup> Annual  
Continuing Education Program

Register online and SAVE the \$50 processing fee: [www.jcahpo.org/ACE](http://www.jcahpo.org/ACE)

Registrations/Cancellations **MUST** be received on or before the following dates:

- Cancellations/Refunds of Virtual Broadcast: **October 15**  
**No Refunds for Virtual On-Demand**
- Transfers of Virtual Broadcast: **November 2**
- Changes: **November 6**
- Final Day to Register: **November 6**

Type or print clearly. Use one form per registrant. Duplicate this form for additional registrants.

IJCAHPO ID # | Government Facility/Duty Location

## REGISTRANT INFORMATION

Please list your credentials \_\_\_\_\_ Date of Birth (mm/dd/yy) / /

Name  Ms.  Mrs.  Mr. ( \_\_\_\_\_ )

First

M.I.

Last

Former name, if applicable

Home Address \_\_\_\_\_ City \_\_\_\_\_ Province/State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Preferred Telephone - - Preferred Email Address \_\_\_\_\_

Which category best describes your professional activities? (Check all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Administration/Management   | <input type="checkbox"/> Contact Lenses   | <input type="checkbox"/> Nursing                | <input type="checkbox"/> Scribe  |
| <input type="checkbox"/> Clinical Research           | <input type="checkbox"/> Front Office     | <input type="checkbox"/> Ophthalmic Photography | <input type="checkbox"/> Student (Program Director): _____                         |
| <input type="checkbox"/> Clinical/Diagnostic Testing | <input type="checkbox"/> Laser Technology | <input type="checkbox"/> Optical                | <input type="checkbox"/> Surgical Assisting  |
| <input type="checkbox"/> Coding Specialist           | <input type="checkbox"/> Low Vision       | <input type="checkbox"/> Orthoptics             | <input type="checkbox"/> Surgical Coordinator <input type="checkbox"/> Other _____ |

Number of years worked in ophthalmology: \_\_\_\_\_ Number of years with current employer: \_\_\_\_\_

## EMPLOYER INFORMATION

Name of Practice \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ Province/State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Business Telephone - - Ext. \_\_\_\_\_ Fax Number - -

Employer's Practice Emphasis (Check all that apply)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Cataract and IOL            | <input type="checkbox"/> Glaucoma                            | <input type="checkbox"/> Ophthalmic Pathology               | <input type="checkbox"/> Refractive Surgery          |
| <input type="checkbox"/> Comprehensive Ophthalmology | <input type="checkbox"/> Low Vision                          | <input type="checkbox"/> Optical Dispensing                 | <input type="checkbox"/> Retina and Vitreous Disease |
| <input type="checkbox"/> Contact Lens                | <input type="checkbox"/> Neuro-Ophthalmology                 | <input type="checkbox"/> Pediatric Ophthalmology/Strabismus | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Cornea and External Disease | <input type="checkbox"/> Oculoplastic/Reconstructive Surgery |   |  |

## METHOD OF PAYMENT Registrations received without payment will NOT be processed.

- Check  Money Order  VISA  MasterCard  Discover  American Express

If paying by check or money order, please make payable to **IJCAHPO**. Checks must be in U.S. dollars.

If paying with a credit card, please complete the information below.

A \$25 fee will be assessed for declined checks and declined credit cards.

IJCAHPO reserves the right to adjust registration charges originally paid with a credit card via fax, mail, or internet if the amount originally paid was deficient or excessive. The credit card account will be charged or credited and the cardholder will be provided with a notice of the adjustment.

Card # \_\_\_\_\_ Expiration Date / Security Code \_\_\_\_\_

Payer's Name (Please PRINT) \_\_\_\_\_

Payer's Billing Address \_\_\_\_\_ City \_\_\_\_\_ Province/State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Authorized Signature **X** \_\_\_\_\_

Please indicate registration selections on reverse side. →

- Register online at [www.jcahpo.org/ACE](http://www.jcahpo.org/ACE) and click on REGISTER
- Send registration form with payment to: IJCAHPO, 2025 Woodlane Drive, St. Paul, MN 55125-2998
- Fax: 651-731-0410

Questions? 800-284-3937. To avoid duplication, please do not mail and fax registrations.

