FAX TO: Michele Vanderwarker at 954-340-7943

I will be attending the AMO/VISX® System Operator Training Certification Course

ADVANCE REGISTRATION FORM

(Please send a copy of this form to any other
laser refractive practice affiliated with your center)

Center or Practice Name _____

Address _____

City_____ State_____ Zip_____

Phone_____ Fax _____

Chief MD Name _____

Attendee Name (Please Print) _____

Attendee Title (Please Print) _____

You may pre-register for the sessions below. Place a (X) mark for the course below.

AMO/VISX
3400 Central Expressway
Santa Clara CA 95051
(8:30am – 4pm PST)

___ November 27, 2007

Number of people attending_____ at $500.00/person TOTAL: $_____

_____Visa _____Mastercard _____American Express _____ Check

Card #: _____ Expiration Date: _____

Cardholders Name (please print): _____

Cardholders Signature: _____

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