

Georgia Orthopaedic Society 2010 Annual Meeting Registration Form

October 14-17, 2010

The Cloister, Sea Island, Georgia

DEADLINE FOR CLOISTER BLOCK OF ROOMS: OCTOBER 1st, 2010

DEADLINE FOR MEETING PRE-REGISTRATION: OCTOBER 4, 2010

Please send completed meeting registration form and check to:

Georgia Orthopaedic Society, 131 Holly Springs Drive, Peachtree City, Georgia 30269.

Phone: 478-474-2754. Fax: 678-669-2754. Email: linearygos@gmail.com

Register Directly Online at www.georgiaorthosociety.com

NAME: _____

(Please list as you would prefer your name badge to read.)

Spouse/Guest Name _____

Mailing Address: _____

PHONE: _____ FAX: _____ EMAIL: _____

REGISTRATION CATEGORY (check only one):

_____ GOS Member _____ Resident Member _____ GOS Candidate for Membership
_____ Guest _____ Resident Guest _____ Allied Medical Professional (PA, NP, RN)

ACCOMMODATIONS:

_____ THE CLOISTER _____ OTHER

Reservations should be made directly with the Cloister at 800-732-4752. Please ask for the GOS block of rooms at the rate of \$279.00 or \$325.00 per night – based on availability.

SOCIAL EVENTS REGISTRATION:

Thursday, October 14th, 6:30pm

Cocktail Reception

YES _____

Attending _____

N/C

Friday, October 15th, 7:00pm

Dinner Dance Banquet

YES _____

attending _____

\$125 per person

Saturday, October 16th, 6:00pm

Cocktail Party

YES _____

Attending _____

N/C

_____ **NO, I will not be attending the Social Events**

Children are welcome to attend the Thursday and Saturday evening events. Sports, Spouse Breakfast, and other social events registration will be mailed separately.

Meeting Fees

Attending

Registration Fee for GOS Members - \$250

Registration Fee for Non-Members - \$350

Registration Fee for Allied Professionals - \$175

Registration Fee for Residents, Spouses, Exhibitors - No Charge

Friday Dinner Dance Banquet - \$125

Late Fee - \$25 (For registrations rec'd after Sept 21st)

Total Amount Enclosed - \$ _____

Checks should be made payable to the Georgia Orthopaedic Society

Payment Information: I authorize the following amount to be charged to my credit card: (Visa/MC/AMEX)

Name on Card _____

Billing Address w/ Zip Code _____

Card Number _____ AVS(3 digit # on back) _____

Expiration Date _____

Please Note: An additional \$15 will be charged to your card to cover fees.

Cancellation Policy: Refunds will not be granted for cancellations received after October 6, 2010.