

Georgia Orthopaedic Society 2011 Annual Meeting Registration Form

September 22-25, 2011

The Cloister, Sea Island, Georgia

DEADLINE FOR CLOISTER BLOCK OF ROOMS: AUGUST 22, 2011

DEADLINE FOR MEETING PRE-REGISTRATION: AUGUST 29, 2011

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: lnearygos@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 \$355.00

SOCIAL EVENTS REGISTRATION:

Thursday, September 22nd, 6:30pm

Cocktail Reception YES _____ # Attending _____ N/C

Friday, September 23rd, 7:00pm

Dinner Dance Banquet YES _____ # attending _____ \$125 per person

Saturday, September 24th, 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 1st)	_____
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 or 4 digit # on back or front) _____

Expiration Date _____

Please Note: An additional \$10 will be charged to your card to cover fees.

Cancellation Policy: Refunds will not be granted for cancellations received after September 15th, 2011.