



NEW YORK STATE
SOCIETY OF OPTICIANS, INC.

TECHNOLOGY IN VISION CARE SUMMIT REGISTRATION FORM

Please complete this form and send it to the address listed below with your payment.

Your Information:

Your Name: _____

Company: _____ Title: _____

Address: _____

City: _____ State/Province: _____ Zip: _____

E-Mail: _____ Phone: _____

Names of Additional People You Are Registering:

_____	_____
_____	_____
_____	_____

REGISTRATION: # _____ NYSSO Member Registration x \$40.00 = \$ _____

Includes lunch, coffee breaks, summit materials and NYS/ABO credits.

_____ NYSSO Non-Member Registration x \$90.00 = \$ _____

Includes lunch, coffee breaks, summit materials and NYS/ABO credits.

PAYMENT:

Total Enclosed: \$ _____

Check #: _____ (Payable to NYSSO) Check Date: _____

Credit Card: Visa Mastercard American Express Discover

Card Number: _____ Exp. Date: _____

Card Holder Name: _____

Signature: _____

QUESTIONS? Please contact NYSSO State Office at 518-426-0599 or nysso@caphill.com.

Return this form with payment to:

NYSSO Technology in Vision Care
1450 Western Avenue, Suite 101
Albany, NY 12203-3539

Phone: 518-426-0599

Fax: 518-463-8656

E-Mail: nysso@caphill.com