

Please fill in the following and fax to 309-836-2455:

Date:

Location:

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Phone: _____

Fax: _____

Confirmation will be sent to e-mail address

Course Fee: \$275.00 per attendee

\$225.00 per additional attendee from same office

_____ 1st attendee \$275.00

_____ 2nd attendee \$225.00

_____ 3rd attendee \$225.00

_____ 4th attendee \$225.00

_____ Total

On-Site Registration is an additional \$25

Credit Card or Check Accepted

__ VISA __ MasterCard Exp.Date _____

Card# _____

Signature _____

Register on-line at www.claimdoctor.net

**Make Check payable to:
Optometric Billing Consultants
Mail check and registration to:
Optometric Billing Consultants
PO Box 465
Macomb, IL 61455
Questions Call 309-333-6344**