

MEETING REGISTRATION

Name _____

Practice Name _____

Phone Number _____ *National PAHCOM Number _____

Mailing Address _____

City _____ State _____ Zip _____

Email address _____

Meeting Date _____ Members: \$20.00 Non Members \$25.00

*MUST PROVIDE PAHCOM NUMBER FOR MEMBER DISCOUNT RATE AND BE CURRENT WITH DUES

Amount Enclosed _____ Check made payable to CPCP

Credit Card: Visa Mastercard (Circle One)

Name on Card: _____ Exp _____

Zip Code for authorization _____

Signature _____ Amount: _____

Mail/Email to:

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Cleveland, OH 44128-5512

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