

## CONFERENCE REGISTRATION FORM

### 7th Annual Women's Health Conference

September 29 - October 1, 2025

Sheraton, New Orleans, LA

*Complete this registration form and fax it to CEC at (516) 539-3555.*

*Alternatively, mail the completed form to Continuing Education Company at 250 Palm Coast Pkwy NE, Suite 607-152, Palm Coast, FL 32137.*

#### Attendee Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Attendee's Email \_\_\_\_\_ Administrator's Email \_\_\_\_\_

Practice/Organization Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State/Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Specialty \_\_\_\_\_

Years Practicing \_\_\_\_\_ Title (MD/DO/NP/PA/Other) \_\_\_\_\_

Patient Population (select the population that best matches your practice) \_\_\_\_\_

How did you hear about this conference? \_\_\_\_\_

Which best describes your practice setting? \_\_\_\_\_

Have you participated in a previous CEC activity (conference, webcast, online course, etc.)? \_\_\_\_\_

Do you practice in a rural area?  Yes  No

#### Payment Information (CHOOSE IN-PERSON OR WEBCAST)

Tuition:

\$725.00 - In-Person  \$625.00 - Virtual Livestream Webcast

Payment Method:

Credit Card (VISA, MASTERCARD, or AMEX)

Card Number \_\_\_\_\_ Name on Card \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Number (on back of card) \_\_\_\_\_

Billing Address (if different from above) \_\_\_\_\_

Check (make payable to Continuing Education Company, Inc. and mail to 250 Palm Coast Pkwy NE, Suite 607-152, Palm Coast, Florida 32137)