Para Registration

Mail: 1401 W. Capitol, Ste 247 Little Rock, AR 72201
Fax: 501-372-0233
Phone: 501-661-7675
Online: www.arkansasoptometric.org

Please circle certification needed, if any.

Staff name: ArkABO ABO CPO NCLE NONE

Email:

Emergency contact name & number:

List any food allergies/dietary restrictions:

☐ ***Participate in 5K** ☐ **Will attend TLC Lunch Friday** ☐ **Will attend Essilor Lunch Friday** ☐ **Will attend Awards Lunch Saturday**

Staff name: ArkABO ABO CPO NCLE NONE

Email:

Emergency contact name & number:

List any food allergies/dietary restrictions:

☐ ***Participate in 5K** ☐ **Will attend TLC Lunch Friday** ☐ **Will attend Essilor Lunch Friday** ☐ **Will attend Awards Lunch Saturday**

Staff name: ArkABO ABO CPO NCLE NONE

Email:

Emergency contact name & number:

List any food allergies/dietary restrictions:

☐ ***Participate in 5K** ☐ **Will attend TLC Lunch Friday** ☐ **Will attend Essilor Lunch Friday** ☐ **Will attend Awards Lunch Saturday**

Staff name: ArkABO ABO CPO NCLE NONE

Email:

Emergency contact name & number:

List any food allergies/dietary restrictions:

☐ ***Participate in 5K** ☐ **Will attend TLC Lunch Friday** ☐ **Will attend Essilor Lunch Friday** ☐ **Will attend Awards Lunch Saturday**

Work for Doctor: ____

Phone Number: ____________________________Fax Number:____________________

Mailing Address: ______________________ City __________ State _____ Zip ________

	Before 4/16/18			After 4/16/18		
Para/Staff/Optician Works for ArOA Member OD	# staff _______	X $125=	$_______	# Staff ____	X $150=	$ _____
Para/Staff/Optician Non-Member	# staff _______	X $205=	$_______	# Staff ____	X $230=	$ _____
5K Fun Run/Walk *Must complete form	# staff _______	X $25=	$ _______	# staff ____	X 25=	$ _____
Total	# staff _______		$_______	# Staff ____		$ ______

Credit Card Number ______________________**Ex Date** __________ **CVV**_________

Is the billing address of your credit card the same as your mailing address listed above? ___ Yes ____ No

If not, please complete the following information:

Name on card ______________________________________

Billing Address ____________________________________

Phone Number ______________________________________

Payment must accompany this form to avoid a charge for late registration. Please make checks payable to: *Arkansas Optometric Association*. The meeting is <u>only</u> available as a complete package. Registration fees will not be broken out for those who do not wish to attend all meetings. A refund of registration, minus a $50 cancellation fee, will be made if the request is received before April 17, 2018.