



OPHTHALMIC SUPPORT STAFF COURSE

REGISTRANT INFORMATION:

Date Accomplished _____

Last name _____ First name _____ M.I. _____

Home Address _____

Office Address _____

Email address _____ Mobile number _____

REGISTRATION FEES: Please check *(inclusive of AM Snacks and Lunch)

- | | | | |
|------------|-------------------------|--------------------------|-----------|
| Early Bird | (Before March 15, 2017) | <input type="checkbox"/> | PhP 1,000 |
| Onsite | (After March 30, 2017) | <input type="checkbox"/> | PhP 1,500 |

METHOD OF PAYMENT:

- Direct Payment to PAO Secretariat
- Cash Payment: PhP _____
- Received Date: _____
- Received by: _____
- Check Payment: PhP _____
- Bank/Branch: _____

- Credit Card
- The presence of the CREDIT CARD and CARDHOLDER at the PAO Secretariat's office is MUST. (for card swiping and signature)

PAO Member Endorsement (Signature over Printed name)

Registrant's Signature

FOR MORE INFORMATION PLEASE CALL

The PAO Secretariat
 Unit 815 Medical Plaza Makati Cond., Amorsolo cor dela Rosa Streets, Makati City
 Tel nos. (+632) 813-5318 or 813-5324
 Fax no. (+632) 813-5331