Registration Form

ATTENDEE INFORMATION: (Please print)

First Name _____ Last Name _____

Company _____

Address _____

City _____ State _____ Zip _____ Country _____

Phone _____ Email _____

REGISTRATION FEES:

$400 by Feb. 28, 2023

$500 after Feb. 28, 2023

$100 Gala Dinner Guest (per guest)

Guest Name(s): _____

_____

_____

Registration Amount: $_____

Gala Dinner Guest(s) $_____

Total Amount: $_____

I will be attending the following sessions:

- ☐ Friday, April 28, 2023, Imaging Conference
- ☐ Friday, April 28, 2023, Welcome Reception
- ☐ Saturday, April 29, 2023, Academic Session 1
- ☐ Saturday, April 29, 2023, Dinner Gala
- ☐ Sunday, April 30, 2023, Academic Session 2

PAYMENT INSTRUCTIONS:

Make checks payable to:

Hawaii Macula and Retina Institute

Mail check payments and registration forms to:

Hawaii Macula and Retina Institute
ATTN: Sheila Chamian
98-1079 Moanalua Road, Suite 470
'Aiea, Hawai'i 96701

Credit Card Authorization Form

CARDHOLDER NAME: (As appears on the credit card)

First Name _____ Last Name _____

Company _____

Address _____

City _____ State _____ Zip _____ Country _____

Phone _____ Email _____

Credit Card Type:

☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other: _____

Credit Card Number _____ Exp _____

Security Code/CVC/CVV: _____ Amount to Charge $ _____

AUTHORIZATION:

I authorize Hawaii Macula and Retina Institute to charge my credit card provided herein for the amount listed above. I agree that I will pay for this amount in accordance with the issuing bank cardholder agreement.

Signature _____ Date _____

For credit card payments, please complete credit card authorization form and fax form to Sheila Chamian at 808-487-3699

Please return this form by mail to:

Hawaii Macula and Retina Institute
ATTN: Sheila Chamian
98-1079 Moanalua Road, Suite 470
'Aiea, Hawai'i 96701

As a security precaution, please do not send credit card information to any email account.

Imaging Conference Submission Form

ABSTRACT INFORMATION:

Title _____

Title Cont. _____

Author(s) _____

Author(s) Cont. _____

Address _____

City _____ State _____ Zip _____ Country _____

Phone _____ Email _____

FORMAT:

Abstract must include Purpose, Methods, Results and Conclusion.

SUBMISSION:

Please submit abstracts to:

Sheila Chamian / 30th Anniversary Meeting
98-1079 Moanalua Road, Suite 470
'Aiea, Hawai'i 96701
Phone Number: 808-380-8060
Fax Number: 808-380-2859
Email: Sheila@RetinaHI.com
RetinaHawaii@AOL.com

DEADLINE:

Please submit your abstract by Feb. 28, 2023.

Free Paper Submission Form

ABSTRACT INFORMATION:

Title _____

Title Cont. _____

Author(s) _____

Author(s) Cont. _____

Address _____

City _____ State _____ Zip _____ Country _____

Phone _____ Email _____

FORMAT:

Abstract must include Purpose, Methods, Results, and Conclusion

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Phone Number: 808-380-8060
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RetinaHawaii@AOL.com

DEADLINE:

Please submit your abstract by Feb. 28, 2023.

Celebrating 30 Years

HAWAIʻI PACIFIC HEALTH | PALI MOMI MEDICAL CENTER