ISMA Professional Development Registration Form

Program name: Medical Business Specialist Certification

Name _____

Title _____

E-mail_____

Organization _____

Address _____

City_____State___Zip __

Telephone:_____

Fax: _____

Are you employed by an ISMA member? _____ □yes □no

Member name: _____

Registration Fees each person/each program

MBS Enrollment $99.00

Total Amount Due $_____

I will be paying by:

□ Check - make *payable to Indiana State Medical Association*

□ Charge: □ VISA or □ MasterCard

Acc't. # _____

Exp.Date _____

Print name of cardholder: _____

Signature of cardholder: _____