Kentucky Osteopathic Medical ASsociation

### 2025 Annual CME COnference Registration FOrm

### June 6 – 7, 2026

### TownePlace Suites, Lexington, KY Keeneland/Airport

Registration Details

DR  MR  MRS  MS \_\_\_\_\_\_\_\_\_

Last Name: First Name:

Company/Institution: Board Certification:

Home Address:

City: State: Zip Code:

Phone: Cell Phone:

Personal Email:

**Wo**rk Address:

City: State: Zip Code:

Phone: Fax:

Work Email:

Registration Fee

*Become a member when registering to this CME event and benefit from the discounted members’ rate.*

|  |  |  |
| --- | --- | --- |
| **Registration Type** | **Cost** | |
| **Physician- KOMA Member** |  | $300 |
| **Physician- (Full member of a non-Kentucky osteopathic society)- proof needed** |  | $300 |
| **Physician- Non-Member** |  | $550 |
| **Physician- Retired** |  | $250 |
| **Resident Physician- Member** |  | $100 |
| **Resident Physician- Non-Member** |  | $200 |
| **Medical Student- Member** |  | $25 |
| **Medical Student- Non-Member** |  | $50 |

*The registration fee includes workshop material, coffee breaks and lunch.*

Membership – 2025 Dues

| Licensed Physician | $200 |  |
| --- | --- | --- |
| Resident Physician | $50 |  |
| Medical Student | $25 |  |
| Out of State DO (non-voting) | $100 |  |

COntinuing Education Credits

|  |  |  |  |
| --- | --- | --- | --- |
| AOA # |  |  | **You must turn in your signed attestation form to receive credits** |
| Category 1 A Credits | Yes | NO |  |
| Specialty Credits Requested | Primary Specialty: |  |  |

Cancellation Policy

Refund Requests must be sent in writing to KOMA no later than May 31, 2025. The reason for the refund/cancellation must be specifically indicated in the letter. There will be a $50 service charge for all refunds.

Support A Student

*Contribution to support a Student Registration Scholarship (optional)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| $50 | $ 100 |  | $ 250 | Other | \_\_\_\_\_\_\_\_\_\_ |

Payment information

|  |  |
| --- | --- |
| **Conference Registration** | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Membership Fee** | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Support a Student** | \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **TOTAL PAYMENT DUE** | \_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CREDIT CARD:**  American Express  MasterCard  VISA.  **Billing Zip Code**:\_\_\_\_\_\_\_\_\_ | | | | | |
| **Cardholder** |  | | **Amount:** | …………….…….…… | |
| **Card #:** |  | **Exp date:** |  | **Security Code (CVC):** |  |
| **Date:** | \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Signature:** |  | | |

**Mail to: Sarah Crawford 184 Sycamore Street Pikeville, KY 41501**

**or email to Komaexec@gmail.com**