



Annual Meeting Registration

Annual Meeting of the Colorado Medical Society/Connection
Vail Cascade & Conference Center, Vail • September 9-12, 2010

Name (please print) _____

Component Society _____

Name of Spouse/Guest(s) _____

CMS Connection Member Yes No My physician spouse will not attend, please send handbook to my attention

If you are not a member of CMS, please provide the following information and \$125 for registration fees:

Company/Organization _____ Title _____

Registration deadline is August 26, 2010. Registrations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, **Connection members and staff of county medical societies are considered members.** You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

Complimentary Events for CMS or Connection Member & Spouse/Guest

Except for the COMPAC Luncheon, you and one guest are entitled to attend all events at no charge.

To confirm your reservation, use the boxes below for yourself and one guest and the shaded area for additional guests.

Thursday, September 9		member	spouse/guest
7:30 pm	Welcome Reception	<input type="checkbox"/>	<input type="checkbox"/>

Friday, September 10		member	spouse/guest
12:00 pm	AMA Forum Lunch	<input type="checkbox"/>	<input type="checkbox"/>
		Meat <input type="checkbox"/>	Vegetarian <input type="checkbox"/>
6:00 pm	Exhibitor Reception	<input type="checkbox"/>	<input type="checkbox"/>

Saturday, September 11 (Complimentary for member & one guest only)

7:00 am	Breakfast Buffett	<input type="checkbox"/>	<input type="checkbox"/>
8:00 am	Education Program	<input type="checkbox"/>	<input type="checkbox"/>
5:30 pm	Candidate Reception	<input type="checkbox"/>	<input type="checkbox"/>
6:00 pm	Inaugural Gala		
	Meat Dinner	<input type="checkbox"/>	<input type="checkbox"/>
	Vegetarian Dinner	<input type="checkbox"/>	<input type="checkbox"/>
	Vegan Dinner	<input type="checkbox"/>	<input type="checkbox"/>

CHARGES FOR ADDITIONAL GUESTS	
# _____	@ \$35/each _____
# _____	@ \$105/each _____
# _____	@ \$105/each _____
# _____	@ \$105/each _____

Non-complimentary events Saturday, September 11

12:00 pm COMPAC Luncheon* Meat Vegetarian

* CHARGE PER PERSON FOR ALL MEMBERS AND GUESTS # _____ @ \$40/each

TOTAL amount enclosed for non-members, additional guests and COMPAC Luncheon. \$

Please make check payable to: **Colorado Medical Society** and mail this form,

or charge Visa MasterCard Am. Express # _____ exp. date _____

Signature _____ Billing Zip Code _____

Please mail this form to us at PO Box 17550, Denver, CO 80217-0550
phone it to us at 720-859-1001 or 1-800-654-5653 or fax it to us at 720-859-7509

CMS 2010 Annual Meeting Accommodations Reservation Form

Vail Cascade Resort & Conference Center, Vail • Sept. 9-12, 2010

ACCOMMODATIONS

Please indicate your first (1) and second (2) choice: (please use this form for one room only)

ROOM TYPE	NIGHTLY ROOM RATE
Main Lodge	\$149
Deluxe Room	\$169
Mountain Grand Fireplace	\$179
Cascade Suite	\$269-\$299
Presidential Suite	\$500

The above rates do not include resort lodging fee and sales tax which total 15.8%. Check-in time is 4:00 PM and check-out time is Noon. Children 17 and under stay for free in parent's room with existing bedding. Valet \$20 per day – Self park \$15 per day

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NOTE: RESERVATIONS MUST BE RECEIVED BY AUGUST 8, 2010 TO BE GUARANTEED SPECIAL COLORADO MEDICAL SOCIETY RATES.

REGISTRATION INFORMATION

Arrival Date _____ Departure Date _____
Name(s) _____
Address _____
City _____ State _____ Zip _____ Phone _____
Any Special Needs/Requests? _____
E-mail Address: _____

DEPOSIT AND CANCELLATION INFORMATION

A one night deposit is due with registration with remaining balance due upon arrival. Personal check or major credit card may be used for the deposit. Cancellations made **after September 1st** are subject to a one night cancellation fee. No shows, late arrivals and early departures will be assessed the total payment for the full length of stay as originally booked unless room is resold.

Card Type _____ Card # _____ Expiration _____
Name of Cardholder _____

I authorize Vail Cascade Resort to charge my credit card for the deposit for accommodations listed above.

Signature _____

Date _____

MAIL OR FAX

Vail Cascade Resort & Conference Center • e-mail: VCR-groupres@destinationhotels.com
Phone 800-420-2424 • Fax 970-479-7050