

Registration

THE COMPLETE COURSE FOR MEDICAL STAFF LEADERS

Hospital Name _____
Street Address _____
City/State/Zip _____
Phone # _____ Fax # _____
Contact Person _____
Title _____
E-Mail _____

NAMES OF REGISTRANTS

(Please give full names and titles as you would like them to appear on name tags.)

1. Name/Degree/Title _____
E-Mail _____
Date Attending _____
2. Name/Degree/Title _____
E-Mail _____
Date Attending _____
3. Name/Degree/Title _____
E-Mail _____
Date Attending _____
4. Name/Degree/Title _____
E-Mail _____
Date Attending _____

PAYMENT

(\$1,595 Individual; \$4,950 for a team of four, \$950 for each additional registrant after a team of four registration)

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