Registration

Physician-Hospital Contracts Clinic

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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☐ Check enclosed. (*Please make payable to HSM Enterprises.*)

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