

Conference Registration Form

ADVANCE REGISTRATION FEES
CUT-OFF DATE - APRIL 2

TORCH MEMBER	<input type="checkbox"/>	\$225
Second member registrant	<input type="checkbox"/>	\$200
Each additional member	<input type="checkbox"/>	\$180 x ____

NON MEMBER \$325 x ____

ON-SITE / LATE REGISTRATION FEES
Postmarked or received AFTER April 2

MEMBER	NON MEMBER
<input type="checkbox"/> \$265	<input type="checkbox"/> \$350

ONE-DAY REGISTRATION FEES

in advance or on-site; one day only (circle day attending)

MEMBER	NON MEMBER
<input type="checkbox"/> \$80 Wed or Fri	<input type="checkbox"/> \$100 Wed or Fri
<input type="checkbox"/> \$130 Thurs	<input type="checkbox"/> \$150 Thurs

SPOUSE/GUEST EVENT FEES

Mark each event attending

Wednesday Reception	<input type="checkbox"/>	\$30 Name _____
Thursday Luncheon	<input type="checkbox"/>	\$30 Name _____
Thursday Reception	<input type="checkbox"/>	\$30 Name _____
ANNIVERSARY Dinner	<input type="checkbox"/>	\$45 Name _____

QUESTIONS? Call the TORCH Office at (512)873-0045 or email us at torch@torchnet.org .

VENDORS MAY PARTICIPATE AT A SPONSORSHIP LEVEL ONLY

Registration Information Must Be Complete. (Please Type or Print Legibly)

Conference registration fee is per person and includes program meetings, conference syllabus, handout materials, conference tote bag, refreshments, two breakfasts, one luncheon, two receptions, one dinner and full access to the Trade Show. If you require assistance or have special dietary needs, please contact the conference office.

TYPE OR PRINT NAME AS IT WILL APPEAR ON BADGE: (use separate sheet for additional attendees)

1. NAME: _____	2. NAME: _____
TITLE: _____	TITLE: _____
Hospital/Organization: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Phone: _____	Fax: _____

PAYMENT OPTIONS - Mail Check or Credit Card Information with Registration Form to:
 TORCH Conference, P.O. Box 14547, Austin, TX 78761
Overnight Delivery: 505 E. Huntland Drive, #150, Austin, TX 78752

Make Checks Payable to : TORCH Annual Conference TOTAL Amount Enclosed: \$ _____

TO PAY BY CREDIT CARD: ___ VISA ___ AMEX ___ MASTERCARD ___ DISCOVER EXP Date: ___ / ___ Security Code: ___

Company Name: _____ Card Number: _____

Billing Address: _____ City/ST/Zip _____

Person Authorized to Charge: First Name: _____ Last Name: _____

Signature Authorizing Charge: _____

Email: _____ Phone: _____

Texas Organization of Rural and Community Hospitals

CREDIT CARD PAYMENT FORM

Please Print Clearly

Total Amount Paid: _____	Date: _____
Name as it appears on card: _____ <i>Company and/or Individual Name</i>	
PERSON AUTHORIZED TO CHARGE:	
First Name: _____	Last Name: _____
Card Type: <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> DISCOVER	
Card Number: _____	Expiration Date: _____
Card Security Code: _____	
Signature Authorizing Charge: _____	
Email Address: _____	
Telephone Number: _____	

BILLING ADDRESS

Please enter the following information exactly as it appears on your credit card statement

Address: _____		
City: _____	State: _____	Zip: _____

Payment cannot be processed unless all information is provided.

You may fax the completed form to (512) 873-0046