2010 CAH CONFERENCE HOSPITAL REGISTRATION FORM

REGISTRATION INFORMATION

This registration form is for hospitals ONLY. All other participants may attend the conference only as an exhibitor and/or as a sponsor (refer to the Exhibitor & Sponsor Opportunities for more information). To help us plan properly and ensure optimal processing of conference materials, complete and submit your registration as early as possible.

METHOD OF PAYMENT

You may pay by check or credit card. **If paying by credit card, complete the form on the back**. Cash is accepted for on-site registration only (receipts will be provided). Your registration cannot be processed without payment.

SUBSTITUTION & CANCELLATION

Registrants unable to attend may send an alternate; please notify TORCH/Foundation of any changes prior to the event. For cancellation, notify us in writing prior to **June 21, 2010**. Refunds, minus a $25 processing fee, will be available for notices received by this date. No refunds will be issued for cancellations received after this date. TORCH/Foundation reserves the right to cancel or reschedule the event if deemed necessary; or should a situation beyond the control of TORCH/Foundation arise to prevent holding the conference, TORCH/Foundation will not be held liable for any expenses incurred by the registrants, except for the registration fee, which would be refunded.

QUESTIONS

For questions regarding registration, confirmation or cancellation, please contact Rose Valenzuela at 512-873-0045 or email at rose@torchnet.org.

Please type or print clearly. You may attach your business card with this completed form.

Name (to appear on badge): ______________________________

Title: ______________________________

Hospital / Healthcare Organization: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Phone: ______________ Fax: ______________ Email: ______________

Additional Hospital Participants (duplicate form for more registrants)

2. Name: ______________ Title: ______________ Email: ______________

3. Name: ______________ Title: ______________ Email: ______________

4. Name: ______________ Title: ______________ Email: ______________

5. Name: ______________ Title: ______________ Email: ______________

Registration *before* June 21, 2010 (per person)

TORCH or Foundation Member: **$50**

Non-member: **$100**

Registration *after* June 21, 2010 (per person)

TORCH or Foundation Member: **$100**

Non-member: **$150**

Total Amount Enclosed: $__________ **Or, Credit Card payment ON BACK**

If paying by check, make checks payable to: TORCH, mail form and payment to: PO Box 14547, Austin, TX 78761

If paying by credit card, complete form on back; if submitting via fax, send both sides of the form to (512) 873-0046.

TORCH CREDIT CARD PAYMENT for the
2010 Critical Access Hospital Conference (Hospital) Registration

Please Print Clearly

Total Amount Paid: ______________________ Date: ______________________

Name as it appears on card: ______________________
Company and/or Individual

PERSON AUTHORIZED TO CHARGE:

First Name: ______________________ Last Name: ______________________

Card Type: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

Card Number: ______________________ Expiration Date: ______________________

Card Security Code: ______________________
3-digit number on back of card, 4-digit on front for AMEX

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.

If paying by credit card, you may mail the form to TORCH, PO Box 14547, Austin, TX 78761 or fax both sides of the application form to (512) 873-0046.