

2012 Program Registration Form

Space in each program is limited. Early registration is recommended. Registrations are accepted on a first come, first served basis. Be sure you receive confirmation of your registration from AAAHC before making travel arrangements.

1. Please select from: **Orlando, FL** March 16-17, 2012
Register by these dates and get the early bird rate: **Early bird:** February 29
- Portland, OR** June 15-16, 2012
Early bird: May 24
- Chicago, IL** Sept. 14-15, 2012
Early bird: August 23

2. Complete the information below for each registrant. If there are more than two registrants, please complete an additional form.

Registrant 1 Name and Credential(s)

Email Address

Check your rate (see early bird dates above) for the *Achieving Accreditation* conference selected:

- Early bird rate - \$785
 Regular rate - \$885

Please select the three sessions (one from each time slot) you plan to attend on Saturday afternoon:

1:00-2:00 pm

- Ask the APIC Expert – Surgery Focus
 Benchmarking for Performance Improvement

2:15-3:15 pm

- Life Safety Code for Medicare ASCs
 Ask the APIC Expert – Primary Care Focus

3:30-4:30 pm

- Preparing for a Medicare Deemed Status Survey
 Medical Home

Registrant 2 Name and Credential(s)

Email Address

Check your rate (see early bird dates above) for the *Achieving Accreditation* conference selected:

- Early bird rate - \$785
 Regular rate - \$885

Please select the three sessions (one from each time slot) you plan to attend on Saturday afternoon:

1:00-2:00 pm

- Ask the APIC Expert – Surgery Focus
 Benchmarking for Performance Improvement

2:15-3:15 pm

- Life Safety Code for Medicare ASCs
 Ask the APIC Expert – Primary Care Focus

3:30-4:30 pm

- Preparing for a Medicare Deemed Status Survey
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3. Provide organization information

Organization Name

Organization Specialty

Please specify the setting in which you work (e.g. ASC, office-based surgery, student health etc.)

Address

City State Zip

Phone

Contact Name (if different from registrant) Contact Phone

Is your organization a Medicare certified ASC, or (for new ASCs) will you be seeking Medicare certification for your ASC?

- Yes No

4. Provide payment information

I have enclosed a check/money order in the amount of \$ _____

Payable to: Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road, Suite 200, Skokie IL 60077

Please charge my credit card in the amount of \$ _____

- Visa MasterCard American Express Discover

Card Number Expiration Date Security Code

Cardholder Name (please print)

Cardholder Signature

There is a cancellation fee of \$125 per registrant. Registrants unable to attend may send an alternate without a fee. Registrants sending an alternate must notify the AAAHC in writing prior to the first day of the program for which they are registered.

I have read and accept the terms and conditions of AAAHC as described in this registration form.

Name

Signature Date

Please fax completed form to AAAHC at 847-324-7717

If you have questions about registration, call 847-853-6060

Americans with Disabilities Act: If you need any of the auxiliary aids or services identified in the Americans with Disabilities Act in order to attend this program, please let us know.