2009 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.

ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

1. Please select

☐ Chicago, Illinois
September 11-12, 2009

☐ Las Vegas, Nevada
December 4-5, 2009

2. Determine registration fees

	Dates offered: September	Dates offered: December	First Registrant	Each additional registrant (from the same organization)
Achieving Accreditation—AAAHC accredited	✓	✓	$635	$585
Achieving Accreditation— non-accredited	✓	✓	$735	$685
'My QI' Workshop	✓		$150	$150
National Educational Forum—AAAHC accredited		✓	$500	$450
National Educational Forum—non-accredited		✓	$600	$550
Both Achieving Accreditation and National Educational Forum—AAAHC accredited		✓	$900	$850
Both Achieving Accreditation and National Educational Forum—non-accredited		✓	$1050	$1015
If registration is received by AAAHC within 30 calendar days prior to the program start date, add late fee:	✓	✓	WAIVED	WAIVED

3. Provide details for each registrant

Two registrants per form

	Achieving Accreditation	'MY QI ' Workshop (Sept. only)	National Educational Forum (Dec. only)	Both Achieving Accreditation and National Educational Forum (Dec. only)	Late Fee (if applicable)	TOTAL
	$	$	$	$	$	$
Name and Credential(s)	$	$	$	$	$	$
Name and Credential(s)					**TOTAL =**	**$**

Attendee 1 E-mail (Required)

Attendee 2 E-mail (Required)

If attending the AAAHC Institute's National Educational Forum in December, please indicate what you consider to be your level of QI expertise:

Attendee 1: ☐ Level I (basic) ☐ Level II (advanced)
Attendee 2: ☐ Level I (basic) ☐ Level II (advanced)

4. Provide organization information

Organization Name

Organization Setting (e.g. ASC, office based surgery practice, student health service, etc.)

Organization Speciality

Address

City State Zip

Phone

Contact Name (if different from registrant) Contact Phone

Please fax completed form to AAAHC at 847/ 853-9028.

5. 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

Cancellations and substitutions 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

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.