

REGISTRATION FORM

Annual Gathering for Licensed Facilitators
Leading an Empowered Organization



Program Dates: June 15-17, 2010

Location: Minneapolis, MN

Tuition: \$500 per person

Enclosed is a check for \$_____ payable to Creative Health Care Management

MasterCard Visa Amex Expiration date _____

Acct # _____ - _____ - _____ - _____

Please mark here if sending a check in the mail

Please mark here if you would like to be invoiced

Please write where the invoice should be sent if different then the name/address below.

Upon receipt of registration, payment must be received within 2 weeks. Space for the class is limited. To avoid cancellation fees, it is required you notify the CHCM office if you are not planning to attend and have turned in a registration form.

Attendee's Information

Form with fields for Full Name (Last, First, Title), Facility, Address (Street Address, Apartment/Unit #, City, State, ZIP Code), Phone, Fax, and E-mail Address.

Details: Please go to www.chcm.com There you will find a link to the participant letter which will provide information on travel and hotel location.

Questions Contact: Amy Monroe; Program Coordinator Phone: 952.252.1145 or 800.728.7766 Email: amonroe@chcm.com

Special Needs for Food: For your upcoming CHCM class, please let us know of special needs for food_____

Return this form to: Fax: 952.854.1866

Important Note: If you cancel your registration less than two (2) weeks prior to the start date of the class, you will be accountable and charged for 50% of the registration fee.