

# Spring Conference on Correctional Health Care

April 5-8, 2014 | Hyatt Regency Atlanta | Advance Registration Form

Use this form or register online for immediate confirmation.

## STEP 1 - NAME/ADDRESS

Complete a separate form for each registration. Registration will not be accepted without a full name. Print or type clearly.

Name \_\_\_\_\_ Degree \_\_\_\_\_ ☐ Male ☐ Female

Employer \_\_\_\_\_ Title \_\_\_\_\_

Mailing Address ☐ Home ☐ Work \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_ National Provider ID# \_\_\_\_\_

## STEP 2 - REGISTRATION

	THRU 2/27/14	2/28/14 THRU 4/4/14	
Regular Registration	<input type="checkbox"/> \$345	<input type="checkbox"/> \$395	\$ _____
Academy Member Registration (see Step 4 below) (Member ID # _____)	<input type="checkbox"/> \$270	<input type="checkbox"/> \$320	\$ _____
One Day Registration <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday	<input type="checkbox"/> \$195	<input type="checkbox"/> \$210	\$ _____
Guest Registration (Guest Name _____)	<input type="checkbox"/> \$65	<input type="checkbox"/> \$65	\$ _____
Exhibits Only (Qualified Professionals Only)	<input type="checkbox"/> \$65	<input type="checkbox"/> \$65	\$ _____

## STEP 3 - PRECONFERENCE SEMINARS

**Saturday, April 5, 9:00 am-5:00 pm**

☐ P-01 NCCHC Standards for Jails and Prisons ☐ \$185 \$ \_\_\_\_\_

**More Seminars To Be Announced**

## STEP 4 - ACADEMY MEMBERSHIP

NCCHC is pleased to offer members of the Academy of Correctional Health Professionals a discount on the conference registration. To qualify, simply indicate below that you would like to join the Academy and include the \$75 membership dues in your conference registration fees. If you are already a member, you may renew your membership below. CCHPs receive a 33% discount and pay only \$50!

	Join	Renew	
Regular Member	<input type="checkbox"/> \$75	<input type="checkbox"/> \$75	\$ _____
CCHP Member	<input type="checkbox"/> \$50	<input type="checkbox"/> \$50	\$ _____

## STEP 5 - PAYMENT FEIN: 36-3221830

Billing Fee\*\* (if applicable) ☐ \$30 \$ \_\_\_\_\_

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ Check Enclosed Payable to NCCHC **TOTAL ENCLOSED \$ \_\_\_\_\_**

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cardholder Name \_\_\_\_\_

Signature \_\_\_\_\_ Security Code \_\_\_\_\_

Billing Address (if different from above) \_\_\_\_\_

☐ \*\*Please invoice my facility. Purchase orders accepted only from government agencies and their contractors. Purchase order must accompany registration form. There is a \$30 service charge for invoice processing.

Office Use



**National Commission on Correctional Health Care**

PO Box 11117 • Chicago, Illinois 60611

Phone: (773) 880-1460 • Fax: (773) 880-2424

info@ncchc.org • www.ncchc.org