PLEASE COMPLETE ALL FIELDS

Full Name: _____ Provider License Type: _____
(ie; MD, DO, RN, NP, PA, or N/A)

Hospital Affiliation: _____ Area of Specialty: _____
(please avoid abbreviations)

Position/Title: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Email Address: _____
all correspondence, including confirmation, payment receipt, announcements, and updates will be sent via email.

PLEASE CIRCLE YOUR SELECTED RATE

Physicians	$145
Nurses, Residents, Allied Health Professionals	$100

Attendance is required at the entire program to receive credit.

CONFERENCE CANCELLATION POLICY: Requests for refunds must be submitted in writing to **emckinney@capitalhealth.org** and received prior to October 31. Your refund minus a $25 processing fee will be mailed to you after the conference. Registrants who fail to attend the conference are responsible for the entire fee.

In the event of circumstances beyond its control, Capital Health reserves the right to cancel the conference. Capital Health is not liable for any expense incurred by participants as a result of cancellation.

PAYMENT:

☐ **Check** payable to "Capital Health System"
(Tax ID# 22-3548695)

Please send the completed registration form with the payment check to:

CLINICAL INNOVATIONS
IN ADVANCED STROKE CARE
c/o Ellen McKinney,
Capital Institute for Neurosciences
750 Brunswick Avenue
Trenton, NJ 08638

☐ **Credit Card**

Name on Card: _____

CC #: _____

Exp. Date: _____ CCV: _____

☐ Billing address is the same as the registrants address

Please contact Ellen McKinney at **609.815.7790** or email **emckinney@capitalhealth.org** with registration questions or if you have any special needs.

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