AtlantiCare NEUROSCIENCES INSTITUTE
A MEMBER OF GEISINGER HEALTH SYSTEM

a member of Jefferson. Neuroscience Network

# 7TH ANNUAL REGIONAL NEUROSCIENCES CONFERENCE AND STATE OF THE ART STROKE SUMMIT SEPTEMBER 7-8, 2017

## ATLANTICARE EMPLOYEE - REGISTRATION FORM

To register, please complete this form and mail or fax (609-441-8178) with full payment to:
ARMC Neurosciences Institute, 1925 Pacific Avenue, 8th Floor, Atlantic City, NJ 08401

*Please make checks payable to:* ARMC Stroke Summit

☐ Physician/PA ☐ Nurse/Allied Health ☒ AtlantiCare Employee

Name:________________________________ Credentials:________________________________

Address: ______________________________ Clock Number: ______________________________

City/State/Zip: __________________________ Work Phone:________________________________

Home Phone: __________________________ Cell Phone: _________________________________

Email Address (REQUIRED): ____________________________________________________________

| Early Registration Before Aug 28 | Physician/PA | Nursing/ Allied Health |
|---|---|---|
| **Sept. 7-8, 2017** (Full Conference – 12 credits) | $220 | $175 |
| **Sept. 7, 2017** (Full Day – 7.5 credits) | $160 | $140 |
| **Sept. 8, 2017** (Half Day – 4.5 credits) | $80 | $60 |

- A $40.00 late fee will be charged for registrations received after Aug 28, 2017.
- Tuition fees include food provided at designated times.
- Four-week cancellation notice is required for a refund.
- Course registration fee is refundable minus a $30 administrative fee.

**Please register me for the following:**

☐ Sept. 7-8, 2017 (Full Conference) $ ___________
☐ Sept. 7, 2017 (Full Day) $ ___________
☐ Sept. 8, 2017 (Half Day) $ ___________
☐ Late Fee after Aug 28 ($40.00) $ ___________
$ ___________ (Total)

**Payment Information: (Choose one)**

Payroll Deduction: ☐

*I authorize AtlantiCare Regional Medical Center to deduct the registration fee for the 7th Annual Stroke Summit 2017 from my pay as follows:*
☐ ONE ☐ TWO consecutive pays.

(Please check preference, if no preference is checked; one consecutive pay will be used)

Employee Name: ____________________

Total Deduction: ____________________

Signature: _____________________________

Clock number: ___________(Required)

**Credit Card:** ☐

☐ Visa ☐ MC ☐ AmEx ☐ Discover

Credit Card Number: ____________________

CVC Code: ___________

Expiration Date: ________ / _______

Cardholder's Name: ____________________

Signature: _____________________________

Billing Address:__________________________