6TH ANNUAL REGIONAL NEUROSCIENCES CONFERENCE AND STATE OF THE ART STROKE SUMMIT SEPTEMBER 8-9, 2016

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. 8-9, 2016 (Full Conference – 12 credits)	$220	$175
Sept. 8, 2016 (Full Day – 7.5 credits)	$160	$140
Sept. 9, 2016 (Half Day – 4.5 credits)	$80	$60

- A $40.00 late fee will be charged for registrations received after Aug 28, 2016.
- 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. 8-9, 2016 (Full Conference) $ _____

☐ Sept. 8, 2016 (Full Day) $ _____

☐ Sept. 9, 2016 (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 6th Annual Stroke Summit 2016 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: _____

Clock number: _____(Required)