



Annual Conference Group Registration

October 18–19, 2019 | Loews Chicago O'Hare | Rosemont, IL

FOR DATA USE ONLY	
Cust# _____	Mtg Ord # 1- _____
Date _____	I _____

Please print clearly. Duplicate and complete page 2 (Annual Conference Individual in a Group) as necessary for each attendee.

Institution or Company Name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Institution or Company phone: (____) _____ Optional phone: (____) _____

Registration Main Contact (full name): _____ Registration Main Contact Role: _____

Main Registration Contact E-mail (required for registration confirmation): _____

List each attendee below. (Each individual must complete and attach an Individual Group Registration form.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

3 Ways to Register

An individual registration form must be submitted for each attendee. All group forms must be submitted together to qualify for group rates.
**Credit card payment only Fax*: 847.375.6395 Phone*: 847.375.4719 Mail: AAHCM Conference, 8735 W. Higgins Road, Suite 300, Chicago, IL 60631*

Full Conference Registration*	A	
	On or Before 9/13/19	9/14/19–10/16/19
Group Rate for up to 5 Attendees	<input type="checkbox"/> \$1300	<input type="checkbox"/> \$1400
Group Rate for up to 10 Attendees	<input type="checkbox"/> \$2500	<input type="checkbox"/> \$2600
Subtotal A \$ _____		

Donation	C
Donations will be directed toward enhancing care delivery and workforce preparedness through research and education.	
<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250	
Subtotal D \$ _____	

Optional Preconference Sessions by HCCI*				B
Thursday, October 17	Clinical Session: 9 am–Noon	Practice Management Session: 1–4 pm	Both Sessions	
Physicians	# Attending _____ \$135 per person	# Attending _____ \$135 per person	# Attending _____ \$240 per person	
Advanced Practice Providers, Residents/Fellow, Practice Managers, Allied Health Professionals	# Attending _____ \$90 per person	# Attending _____ \$90 per person	# Attending _____ \$165 per person	
<small>HCCI HOME CENTERED CARE INSTITUTE</small> *By registering for this event, you authorize HCCI to contact you regarding the event.				Subtotal B \$ _____

Total Amount Due
A + B + C = \$ _____

Cancellation Policy: All cancellations must be made in writing. A \$95 processing fee will apply to all cancellations. No refunds will be made on cancellations postmarked after September 17, 2019. All refunds will be processed after the Annual Meeting. AAHCM and HCCI reserve the right to substitute faculty or to cancel or reschedule sessions due to low enrollment or other unforeseen circumstances. No refunds can be made for lodging, airfare, or any other expenses related to attending the AAHCM Annual Meeting.

Photography Disclosure: A professional photographer may take photos of participants at AAHCM's programs and events. These photos are for AAHCM's use only and may appear on AAHCM's website, in printed brochures, or in other promotional materials. Attendee registration grants AAHCM permission and consent for use of this photography.

PAYMENT
<input type="checkbox"/> Check (enclosed) • Make check payable to AAHCM. • Checks not in U.S. funds will be returned. • A charge of \$25 will apply to checks returned for insufficient funds.
<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> American Express • I authorize AAHCM to charge the below-listed credit card amounts deemed by AAHCM to be accurate and appropriate.
Account number: _____ Exp. date: _____ CW: _____
Signature _____
Cardholder's name (please print) _____
• If rebilling of a credit card charge is necessary, a \$25 processing fee will be charged. If payment does not accompany this form, registration will not be processed.



Annual Conference Individual in a Group

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FOR DATA USE ONLY	
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Date _____	_____

Please print clearly. Complete and attach this form to the first page (Annual Conference Group Registration) for each registrant and duplicate as necessary.

Complete name: _____ First name for badge: _____

Title: _____ Credentials: _____

Company: _____ Company city/state: _____

Mailing address (home work): _____

City: _____ State: _____ Zip code: _____

Home phone: (____) _____ Work phone: (____) _____

E-mail address (required*): _____

**Confirmation of your registration will be sent via e-mail only to the e-mail address you provide here.*

Emergency contact: _____ Emergency contact phone: _____

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Optional Preconference Sessions by HCCI*			C
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Physicians	<input type="checkbox"/> \$135	<input type="checkbox"/> \$135	<input type="checkbox"/> \$240
Advanced Practice Providers, Residents/Fellow, Practice Managers, Allied Health Professionals	<input type="checkbox"/> \$90	<input type="checkbox"/> \$90	<input type="checkbox"/> \$165

HCCI HOME-CENTERED CARE INSTITUTE *By registering for this event, you authorize HCCI to contact you regarding the event.
Additional fee events. Add cost to Group Registration form.

How did you hear about this meeting?
 AAHCM Email Colleague Mailed Brochure Digital Ad/Promo Social Media Other

Please select the position you most identify as:
 Nurse Nurse Practitioner Physician Physician's Assistant
 Practice Manager/Administrator Social Worker Other

How many years have you been in in home care medicine?
 0-1 year 1-5 years 6-10 years 11-15 years 16-20 years 20+ years n/a

If you work in a practice, how many medical providers work in your practice? _____

If you work in a practice, how many total staff work in your practice? _____

A boxed lunch will be provided Friday and Saturday.
 Please select the days we can provide you lunch: Friday Saturday

Special Requests		D
<input type="checkbox"/> I require kosher meals.	<input type="checkbox"/> I require vegetarian meals.	
<input type="checkbox"/> I am a first-time conference attendee.	<input type="checkbox"/> I have other needs. Please contact me.	

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