PARTICIPANT INFORMATION

First name _____ Last name _____

Title and credentials _____

Email (required) _____

Telephone _____ Fax _____

Organization name _____

Street address _____

City _____ State _____ ZIP code _____

☐ I have dietary restrictions or allergies. Please specify: _____

TUITION FEES

☐ IHA/IAFP members – $2,550 ☐ IHA/IAFP Nonmembers – $3,300

☐ Single registration (paid in three installments) $850/$1,100 due at registration, $850/$1,100 due Feb. 14, and $850/$1,100 due April 18.

PAYMENT INFORMATION

☐ Option 1: Bill my institution.

☐ Option 2: Enclosed is my check payable to IHA in the amount of $ _____.

OFFICE USE ONLY

Program No. 125-5130-202825

Date received _____

Fee amount $_____

Check No. _____

Check total $_____

IOWA HOSPITAL ASSOCIATION

Email: iharegistration@ihaonline.org

Website: www.ihaonline.org

Mail: Iowa Hospital Association, Attn: Autumn McGill
100 E. Grand Ave., Suite 100, Des Moines, IA 50309