PHYSICIAN BUSINESS LEADERSHIP CERTIFICATION PROGRAM

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, IMS, IAFP Members – $2,600 ☐ Nonmembers – $3,000 ☐ Executive coaching – $450

☐ Single registration (paid in three installments) $900/$1,000 due at registration, $850/$1,000 due March 23, 2022 and $850/$1,000 due April 26, 2022.

PAYMENT INFORMATION

☐ Option 1: Bill my institution.

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

☐ Option 3: Charge my credit card. I authorize IHA to charge my credit card:

☐ American Express ☐ Discover ☐ MasterCard ☐ Visa

Cardholder's name _____

Card No. _____

Exp. date _____ Security code _____

Signature _____

OFFICE USE ONLY
Program No. 125-5130-202822

Date received _____

Fee amount $ _____

Check No. _____

Check total $ _____

IOWA HOSPITAL ASSOCIATION
We care about Iowa's health

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