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 – $2,850 ☐ Nonmembers – $3,200 ☐ Executive coaching – $450

☐ Single registration (paid in three installments) $950/$1,100 due at registration, $950/$1,100 due Feb. 23, and $950/$1,000 due April 26.

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, please call Corey Martin at IHA.

OFFICE USE ONLY
Program No. 125-5130-202823

Date received ______

Fee amount $ ______

Check No. ______

Check total $______

IOWA HOSPITAL ASSOCIATION
We care about Iowa's health

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