

Payment and Registration Information

2009 West Coast Safe Patient Handling
September 28 – October 1, 2009

The Hilton San Francisco – San Francisco, California

2009 West Coast Safe Patient Handling Registration Form

Name: _____ Credentials: _____ Gender: Male Female
 Preferred Mailing Address: _____
 City: _____ State: _____ Zip Code: _____ Country: _____
 Daytime Telephone: _____ Fax: _____ Email: _____
 License Type: _____ License Number: _____ License State: _____
 Employer: _____
 Please State Any Dietary Restrictions That You Have: _____

Fees and Conference Schedules

PRE CONFERENCE (Monday, September 28th):
DAY LONG PROGRAM (Monday, September 28th):
 On its own \$330.00
 With main conference registration: \$220.00
 Onsite: \$380.00
AFTERNOON PROGRAM (Monday, September 28th):
 On its own \$165.00
 With main conference registration: \$110.00
 Onsite: \$215.00
 Please select which sessions you would like to register for (Monday, September 28th):
 9:00 AM – 3:30 PM Challenges and Solutions for Safe Patient Handling of Bariatric Patients
 9:00 AM – 3:30 PM "Hands-On" Experience with Latest Patient Handling Equipment
 1:00 PM – 4:00 PM Monitoring Effectiveness of Safe Patient Handling Programs
MAIN CONFERENCE (Tuesday, September 29th thru Wednesday, September 30th):
 Early Bird (on or before 8/21/2009) \$500.00
 Regular (after 8/21/2009) \$615.00
 Pre-registration is required for your session of choice for September 29th and September 30th of the main conference for concurrent sessions.
 Please check each section you selected to attend: (Tuesday, September 29th):

| | | | |
|--------------|--------------------------|--------------------------|--------------------------|
| Track | A | B | C |
| 1:30 PM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2:30 PM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3:45 PM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

 Please check each section you selected to attend: (Wednesday, September 30th):

| | | | |
|--------------|--------------------------|--------------------------|--------------------------|
| Track | A | B | C |
| 8:00 AM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10:45 AM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

POST CONFERENCE (Thursday, October 1st):
 On its own \$330.00
 With main conference registration: \$220.00
 Onsite: \$380.00
 Please select which sessions you would like to register for (Wednesday, October 1st):
 Strategic Planning Workshop for Facility Champions: Developing a Facility-Based Action Plan
 Certificate Program to Train Unit-Based Peer Leaders
Total Amount: _____

Payment Information

Enclosed is my check made payable to USF Health Professions Conferencing Corporation (USF HPCC) in the amount of \$ _____
 Please charge my credit card in the amount of \$ _____
 Credit Card: MasterCard Visa American Express
 Credit Card Number: _____ Expiration Date: _____
 Cardholder Name: _____ Signature: _____
 Mail to: Attention: PG2010533/1150, USF Health Professions Conferencing Corporation, P.O. Box 864240, Orlando, FL 32886-4240
 Fax to: 813-974-3217 Register Online at: www.cme.hsc.usf.edu