Top Gun School for Skilled & Subacute Nurses April 24, 25 & May 1, 2018
REGISTRATION

YOU MAY REGISTER IN ONE OF FOUR WAYS:

BY FAX: Fax your completed registration form along with your credit card information to: **609-584-1047**
BY EMAIL: Email your completed form to michelle@hcanj.org
BY MAIL: Mail your completed registration form along with your check or credit card information to:
Health Care Association of New Jersey, 4 AAA Drive, Suite 203, Hamilton, NJ 08691
ONLINE: Visit our website at ***www.hcanj.org*** and click on the ***Events and Education*** tab to find the event

If you have questions regarding the program, please call or e-mail Michelle Palko at 609-890-8700 or michelle@hcanj.org

HCANJ regrets that we are unable to offer refunds for cancelled registrations and no-shows. Registrant substitutions from the same facility are acceptable.

PRINT ALL INFORMATION

NAME_____ TITLE_____

Nurse License #: _____ Email_____

DAY 1 Tues, April 24, 2018 ❑$150 HCANJ MEMBER INDIVIDUAL ❑$250 NON-MEMBER INDIVIDUAL

DAY 2 Wed, April 25, 2018 ❑$150 HCANJ MEMBER INDIVIDUAL ❑$250 NON-MEMBER INDIVIDUAL

DAY 3 Tues, May 1, 2018 ❑$150 HCANJ MEMBER INDIVIDUAL ❑$250 NON-MEMBER INDIVIDUAL

SPECIAL SAVINGS: Register for the total 3-day program
❑$350 HCANJ MEMBER 3-DAY FEE ❑$650 NON-MEMBER 3-DAY FEE

Facility name_____ Address_____
Street address City State/Zip

Payment method: ❑Check enclosed for $_____ ❑Charge my card for $_____ ❑MasterCard ❑Visa ❑Amex

Credit card no. _____CV2 #_____ Card exp. date_____
*the CV2# is the three or four digit additional black number on the front or back of your credit card. (Example: 4786 **411**)

Credit card information: To whom and where credit card statement is sent:

Cardholder Name:_____ Billing Address: _____
Street address City State/Zip

Cardholder E-mail: _____Cardholder Signature: _____

Contact information of individual responsible for registration:

Name:_____ Title:_____

E-mail: _____ Phone:_____ Fax: _____