

5th Annual Kansas Health Care Ethics Conference

March 28, 2018 Registration Form

Name _____

Address _____

City _____ State _____ Zip _____ Day Telephone _____ - _____ - _____

Email _____

Hospital/Institution Name/City _____

WMC Employee 3/4ID _____ Non WMC Employee last 4 of SSN # _____

License # _____

Check all that apply:

Classification: APRN RN LPN RCP MICT EMT Social Worker Chaplain Physician

Adult Care Home Administrator/Operator

Other please specify _____

Student *Non CEU* (A limited number of student scholarships are available, contact WMREF)

Please check the appropriate selection. Payment must accompany registration.

Fee includes lunch and snacks at breaks.

\$80 if postmarked on or before March 15, 2018

\$90 if postmarked after March 15, 2018

\$100 Walk-in registration (accepted based on availability of space)

\$25 General Public—No CEU

Check enclosed for amount of \$ _____ payable to WMREF

Bill my credit card for the amount of \$ _____

Visa MasterCard Discover # _____

Exp Date _____ Credit Card Signature _____

Complete this form and return with payment to:

Wichita Medical Research & Education Foundation

Attn: Teresa Carter

3306 E Central

Wichita, KS 67208

Or fax to 316.687.0033 (must include credit card payment information)