

# Group Registration



Affiliated Christian Healthcare Organization					
Last Name		First		M.I.	Date
Street Address			Apt/Unit #		
City		State		ZIP	
Phone		E-mail Address			
Current Position					
Are you currently a member of CCHF?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Please check one.		<input type="checkbox"/> Male <input type="checkbox"/> Female
Have you attended a CCHF Conference in the past?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Will you be staying on site?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Will you be attending the site visit?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If staying on site, do you have a roommate request?		
If you are interested in one of the following please check all that apply. You will be responsible for the additional cost which must be paid by May 7, 2010. Thank you.					
Room on Wednesday evening <b>\$45</b>	<input type="checkbox"/>	Do you have any special needs we should be aware of?			
Single room for Thursday and Friday evenings <b>\$90</b>	<input type="checkbox"/>				
Room on Saturday evening <b>\$45</b>	<input type="checkbox"/>				