



# HOME CARE LICENSURE APPLICANT TRAINING

## REGISTRATION

Date of Class: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Owner: *(ALL owners are required to attend)* \_\_\_\_\_

Attendee 2: \_\_\_\_\_

Additional Attendee (s): \_\_\_\_\_

Email Address *(please print legibly)*: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

## PAYMENT

		<u>Subtotal</u>
Class Fee (1-2 Registrants)	_____ @ \$625 <b>OR</b>	\$ _____
Past Attendees wanting to retake course <i>(Past attendance must be verified)</i>	_____ @ \$319	\$ _____
Additional Registrants	_____ @ \$300 each	\$ _____
Policy Manual* <i>*if purchased within 30 days of class</i>	_____ @ \$499 +6.75% tax	\$ _____
<b>TOTAL \$</b>		<b>_____</b>

Enclosed is a money order or cashier's check for the total amount of the registration \$ \_\_\_\_\_  
(PERSONAL CHECKS WILL NOT BE ACCEPTED)

Please charge my credit card for the total amount of \$ \_\_\_\_\_

MasterCard     Visa     American Express     Discover

Credit Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Security code: \_\_\_\_\_

Name (as it appears on card): \_\_\_\_\_

Address of Cardholder: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

### Confirmations and Cancellation Policy

A final confirmation will be sent via email to registrants at least one week prior to the workshop.

*In the event of registrant cancellation, fees are not refundable.*

Please contact Richard Fowlkes if you have any questions about registration by calling  
919.848.3450 or 800.999.2357.

PLEASE FAX COMPLETED FORM TO 919.848.2355 OR MAIL TO

Association for Home & Hospice Care of North Carolina

3101 Industrial Drive, Suite 204 | Raleigh, NC 27609 | [www.homeandhospicecare.org](http://www.homeandhospicecare.org)