shm
Society of Hospital Medicine

SOCIETY OF HOSPITAL MEDICINE LEADERSHIP ACADEMY 2015

OCTOBER 19 – 22, 2015 • HYATT REGENCY AUSTIN • AUSTIN, TEXAS

REGISTRATION FORM

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email *(mandatory)*: _____

Special Needs *(e.g., wheelchair access, meal requirement)*: _____

_____

DEMOGRAPHICS:

☐ Medical Director ☐ Associate/Assistant Medical Director ☐ Hospitalist ☐ Administrator/Manager

☐ Other *(please specify)*: _____

SPECIALTY: _____

TUITION:

	SHM Member	Non-Member
☐ Leadership Foundations	$1,795	$1,995
☐ Advanced Leadership: Influential Management	$1,895	$2,095
☐ Advanced Leadership: Mastering Teamwork	$1,895	$2,095

Registrants will receive an email confirmation within two weeks of receipt of registration application.
Cancellations prior to September 7, 2015 will receive full refund less $300 administration fee.
Cancellations on/after September 7, 2015 will not be refundable.

DISCOUNTS:**

☐ 20% discount for groups with more than 20 registrants**

☐ 10% discount for groups of 3-20 registrants**

☐ 10% discount for hospital medicine group leaders who bring their administrators*

****Only one discount can be applied toward registration.***

PAYMENT:

☐ Check enclosed (payable to Society of Hospital Medicine). *Please remit in U.S. funds drawn on U.S. bank.*

CREDIT CARD:

☐ Visa ☐ MasterCard ☐ American Express

CREDIT CARD INFORMATION:

Cardholder's Name: _____

Credit Card Number: _____ Expiration Date: _____ CVV: _____

Total Charged: _____ Cardholder's Signature: _____

Fax Registration Form to: 267-535-2911

Mail Registration Form and Payment: Society of Hospital Medicine • P.O. Box 822898 • Dept. 301• Philadelphia, PA 19182-2898

For Additional Information: **Phone:** 800-843-3360 **Email:** meetings@hospitalmedicine.org

***Turn for Group Registration Information →

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GROUP REGISTRATION FORM

To qualify for the group registration discount everyone in the group must be registered at the same time. To register a group you must list all of the names of the individuals who will be in the group below.

First Name: _____ Last Name: _____

Email *(mandatory)*: _____

Address: _____

City: _____ State: _____ Zip: _____

SHM ID *(not mandatory)*: _____

Course Selection: _____

First Name: _____ Last Name: _____

Email *(mandatory)*: _____

Address: _____

City: _____ State: _____ Zip: _____

SHM ID *(not mandatory)*: _____

Course Selection: _____

First Name: _____ Last Name: _____

Email *(mandatory)*: _____

Address: _____

City: _____ State: _____ Zip: _____

SHM ID *(not mandatory)*: _____

Course Selection: _____

☐ If you would like one invoice for all of the attendees being registered, please check this box. If you would like to register more than three attendees, please photocopy this page and send it in with the necessary information for additional attendees.

For any questions regarding group registrations, please email meetings@hospitalmedicine.org.

Fax Registration Form to: 267-535-2911

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