

# Registration: FILL-IN & PRINT-OUT

**Instructions:** Type to fill-in the blanks. When complete, go to File > Save as > give a file name > and Save! Print out the form and fax or mail in to the address below.

**FAX this form to: 336-832-7591 • Or MAIL to: Greensboro AHEC, 1200 N. Elm St., Greensboro, NC 27401-1020**

**Payment must be received with registration.** Please make checks payable to: **Greensboro AHEC**

If you prefer to register online, go to [gahec.org](http://gahec.org) and click "Search for a Course." Next, click on the course you want to attend. Click on the link at the bottom of the page that says "Click Here To Register Online For This Event" where you are taken to a secure Online Registration Area. Type in your last name and last 4 digits of your social security number and follow the remaining steps.

**Email:** \_\_\_\_\_ (Required) Last 4 digits of SS# \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Certification/Degree \_\_\_\_\_

Home Fax \_\_\_\_\_ Office Fax \_\_\_\_\_

Employer \_\_\_\_\_ Title \_\_\_\_\_

Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Desired Credit \_\_\_\_\_ Discipline: (Select one)  Allied Health  Dentistry  Health Careers

Medicine (MDs only)  Mental Health  Nursing  Other  Pharmacy  Public Health

Specialty \_\_\_\_\_ (Ex. Counselor, Dentist, Physical Therapy, Registered Nurse, Social Worker)

**CPE Monitor Information (For Pharmacist and Pharmacy Technicians only)**



NABP e-Profile ID: \_\_\_\_\_ DOB: MM/DD: \_\_\_\_\_

By providing your fax number, email address and telephone number, you have granted permission for us to contact you via the numbers and addresses indicated.

If you have any food allergies, ADA requirements, or comments please enter them here \_\_\_\_\_

Lunch options:  Regular  Vegetarian  Gluten free

How did you find out about this program?  Brochure or Postcard  Email  Flyer  Website  Facebook  Twitter

**Payment Options: (Check one)**

**Payment must be received with registration.**

Check enclosed  MCHS Internal Transfer: 13-digit Cost Center # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Credit Card

**Indicate Credit Card Type: (these only)**

VISA  MasterCard (NOTE: Your statement will show, "Moses Cone-AHEC") Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Sec. code: \_\_\_\_\_

Billing Name \_\_\_\_\_

Email address \_\_\_\_\_

Address \_\_\_\_\_

Cardholder Signature \_\_\_\_\_



**Course Selections**

EVENT TITLE	EVENT #	EVENT DATE	FEE
_____	_____	_____	_____
_____	_____	_____	_____

Total Amount enclosed for Event(s) \$ \_\_\_\_\_