



# WEBINAR REGISTRATION FORM

## CAH CMS Hospital Conditions of Participation 2021: Ensuring Compliance

### FOUR-PART SERIES

May 19 Noon-2 p.m. Central  
May 26 Noon-2 p.m. Central  
June 2 Noon-2 p.m. Central  
June 9 Noon-2 p.m. Central

### REGISTRATION FEE:

	Member	Non-member
Part 1, May 19	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179
Part 2, May 26	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179
Part 3, June 2	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179
Part 4, June 9	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179

### CANCELLATIONS AND SUBSTITUTIONS

Registrants unable to attend may allow an alternate to connect. Transfer from one THA education program to another is not permitted, and no financial credit will be granted. If a registrant cancels, the registration fee, less a 20 percent service charge, is refundable only if THA receives notice in writing no less than five business days prior to the program. (Send notification via e-mail to [registrar@tha.org](mailto:registrar@tha.org) or fax to 512/692-2653). Refunds will be issued only after the program runs and it is verified that the registrant did not access the program.

Total \$

Registration includes unlimited connections per registered facility. We want to ensure that our education is accessible to everyone, please contact us if you have any questions at [servicecenter@tha.org](mailto:servicecenter@tha.org) or 512/465-1057. A recording of this program is also included in the cost of registration.

### REGISTRANT INFORMATION – Please include all information requested.

Please Print. **Payment must accompany registration form.**

Name

Title

Department

Organization

Address

City/State/ZIP

Phone (area code)

Fax (area code)

Email

(\*IMPORTANT\* All correspondence sent to this email)

Enclosed is Check #  payable to THA in the amount of \$ . (There will be a \$25 charge on all returned checks.)

Or I authorize THA to charge my credit card:

Visa  MC  AmEx

Account #

Expiration Date

CVV

Name as Shown on Card

Signature

Billing Address

City/State/ZIP

**ONLINE**  
[www.tha.org](http://www.tha.org)  
**FAX**  
512/692-2653

**MAIL**  
Texas Hospital Association  
P.O. Box 95353  
Grapevine, TX 76099-9733

**REMIT PAYMENT BY ACH**  
Texas Hospital Association  
Account No. 0101887890  
ACH or Transit Routing #111900785

**OVERNIGHT**  
1108 Lavaca, Suite 700  
Austin, TX 78701-2108