



WEBINAR REGISTRATION FORM

CMS Hospital Conditions of Participation Made Easy 2022

FIVE-PART SERIES

- April 6 Noon-2 p.m. Central
- April 13 Noon-2 p.m. Central
- April 20 Noon-2 p.m. Central
- April 27 Noon-2 p.m. Central
- May 4 Noon-2 p.m. Central

REGISTRATION FEE:

	Member	Non-member
Part 1, April 6	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179
Part 2, April 13	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179
Part 3, April 20	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179
Part 4, April 27	<input type="checkbox"/> \$149	<input type="checkbox"/> \$179
Part 5, May 4	<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 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.

Subtotal \$ _____

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 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 _____

_____ Enclosed is my 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 _____

(*IMPORTANT* All correspondence sent to this email)

ONLINE
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