

REGISTRATION INFORMATION

First/Last Name _____

Degree (as you wish it to appear on your badge) _____

Title _____

Facility/Company _____

Address _____

City _____ State _____ Zip _____

Phone () _____ Fax () _____

Email _____ Cell Phone _____

Web Site _____

Guest Name (if registering) _____



PHA MEMBER REGISTRATION FEE

ANNUAL MEETING FEES	Before Sept. 10	After Sept. 10	Amount
1st Person	\$775	\$875	\$ _____
2nd Person	\$750	\$850	\$ _____
3rd Person or more	\$725	\$825	\$ _____
Guest Registration (Reception & social events only)	\$250	\$250	\$ _____
Activity TBD	\$75	\$75	\$ _____
TOTAL AMOUNT ENCLOSED			\$ _____

PHA NON-MEMBER REGISTRATION FEE

ANNUAL MEETING FEES	Before Sept. 10	After Sept. 10	Amount
1st Person	\$875	\$975	\$ _____
2nd Person	\$850	\$950	\$ _____
3rd Person or more	\$825	\$925	\$ _____
Guest Registration (Reception & social events only)	\$250	\$250	\$ _____
Activity TBD	\$75	\$75	\$ _____
TOTAL AMOUNT ENCLOSED			\$ _____

THREE CONVENIENT WAYS TO REGISTER

Mail to: PHA, 5900 S. Western Ave, Ste 102, Sioux Falls, SD 57108

Enclosed is a check, payable to PHA. Check # _____

Fax to: Fax registration form with credit card information to (605) 731-2575

Call: (605) 275-5349

I authorize PHA to charge my: Visa Mastercard American Express Discover

Credit Card Number: _____

Expiration Date: _____

Printed Cardholder Name: _____

Signature: _____

Cancellation: Written cancellation requests must be received by September 17 and refunds are subject to a \$100 processing fee. No refunds will be made after September 17.

QUESTIONS

PHYSICIAN HOSPITALS OF AMERICA
5900 S. Western Ave, Ste 102
Sioux Falls, SD 57108
Phone: (605) 275-5349
Fax: (605) 731-2575
Email: info@physicianhospitals.org
Web: www.physicianhospitals.org

Please use a separate registration form for each attendee. Photocopies are acceptable.