

Registration: 2008 Wisconsin Quality & Safety Forum

Please duplicate this form as needed.

Registration Fee: **Single Rate:** \$300 per person
Team Rate: \$275 per person (Team rate is **three** or more paid attendees from the same facility. Registration and payment must be submitted at the same time.)

Organization Information

Organization _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Attendee Information

Name _____ Title _____

Phone _____ Fax _____

Email _____

Rate: Single Team

Name _____ Title _____

Phone _____ Fax _____

Email _____

Rate: Single Team

Name _____ Title _____

Phone _____ Fax _____

Email _____

Rate: Single Team

Final cut-off date for room reservations is **September 26**.
Conference registrations must be received by **October 6**.

Payment Information

Check Total enclosed: \$ _____ (Make checks payable to Wisconsin Hospital Association)

Visa MasterCard Amount \$ _____ Expiration Date _____

16 Digit Number _____

Name on Card _____

Billing Address (for name on card) _____

Return registration form with your payment to:
Lisa Geishirt, WHA, P.O. Box 259038, Madison, WI 53725-9038, Fax: 608-274-8554