

Georgia Department of Community Health

REGISTRATION FORM

(Please print legibly)

Today's Date:	Return to: HP Enterprise Services 100 Crescent Centre Pkwy. Suite 1100 Tucker, GA 30084
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ATTENDEE INFORMATION

Participant Last Name:	First Name:	MI:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Contact Name:			Contact Preference: <input type="checkbox"/> Email <input type="checkbox"/> Hard Copy <input type="checkbox"/> Fax		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:				
Street Address:					
			Phone ()		
P.O. Box:	City:	State:	ZIP Code:		

*** If you already registered via online there is no need to return this form via USPS.**

Locations:	Workshops:
<input type="checkbox"/> Albany <input type="checkbox"/> Columbus <input type="checkbox"/> Marietta <input type="checkbox"/> Atlanta <input type="checkbox"/> Covington <input type="checkbox"/> Macon <input type="checkbox"/> Athens <input type="checkbox"/> Duluth <input type="checkbox"/> Savannah <input type="checkbox"/> Augusta <input type="checkbox"/> Fitzgerald <input type="checkbox"/> Thomasville <input type="checkbox"/> Brunswick <input type="checkbox"/> Gainesville <input type="checkbox"/> Tifton <input type="checkbox"/> Cartersville	<input type="checkbox"/> Claim Type: Dental <input type="checkbox"/> Claim Type: Institutional <input type="checkbox"/> Claim Type: Professional A <input type="checkbox"/> Claim Type: Professional B <input type="checkbox"/> Claim Type: Professional C <input type="checkbox"/> Claim Type: Institutional Minus Hospital

WORKSHOP INFORMATION

(Select the city closest to you)			Territory Number And City and Date		
1 st Choice	Name of Workshop:		() Territory Number/City:	Date: / /	
2 nd Choice	Name of Workshop:		() Territory Number/City:	Date: / /	
3 rd Choice	Name of Workshop:		() Territory Number/City:	Date: / /	
1 st Choice Session	2 nd Choice Session	3 rd Choice Session			
<input type="checkbox"/> AM (9:30am) <input type="checkbox"/> PM (1:30pm)	<input type="checkbox"/> AM (9:30am) <input type="checkbox"/> PM (1:30pm)	<input type="checkbox"/> AM (9:30am) <input type="checkbox"/> PM (1:30pm)			

Questions or concerns about registration please contact HP Enterprise Services at **(678) 713-3700 ext. 31811**

WORKSHOP'S DETAILED

Institutional	Professional A	Professional B	Professional C	Dental
Inpatient or Outpatient Hospital	Physician's Services	Waivered Services Programs	Public Health Department	Dental
Hospice	Physician's Assistant Services	Case Management Programs	Emergency Ambulance	Adult Dental
Dialysis Facilities	Podiatry	Children Intervention Services	Durable Medical Equipment	
Swing Bed (Transitional Care Unit)	Advanced Nurse	Federally Qualified Health Center (FQHC)	Psychological/Psychologist & Vision Care	
Ambulatory Surgical Centers			Home Health & Hearing Dispenser	
Nursing Facilities			Orthotics and Prosthetics	
			Independent Laboratory	

Signature: _____ *Date:* _____