

Register Now for "A Time to Heal"!

35th Annual National Wellness Conference • July 17-22, 2010

*Each ATTH team must consist of a medical professional (e.g., nurse, physician, P.T.,) who is familiar with cancer survivors AND a mental health professional (e.g., counselor, psychologist, social worker, chaplain) who is familiar with cancer patients. Additional team members are encouraged to take part.

Certificate Program		Registration Fee
<input type="checkbox"/> A Time to Heal (ATTH) All-Cancer Survivorship Program Facilitator Training	Team of Two*	\$2,695
<input type="checkbox"/> ATTH All-Cancer Survivorship Program Facilitator Additional Team Member	Qty _____	\$150 x ____ (qty) = _____
<input type="checkbox"/> ATTH Breast Cancer Survivorship Program Facilitator Cross-Training	Team of Two*	\$1,495
<input type="checkbox"/> ATTH Breast Cancer Survivorship Program Facilitator Cross-Training Additional Team Member	Qty _____	\$150 x ____ (qty) = _____
SAVE! Main Conference Registration <input type="checkbox"/> (7/19 p.m. - 7/22) Select "yes" below for each team member registering for the Main Conference.	Qty _____	\$150 x ____ (qty) = _____
TOTAL (A)		

Today's Date _____

Cancellation Policy: Should you be unable to attend, a substitute delegate is welcome at no extra charge. A charge of 25% of the registration fee will be made for cancellations received in writing by July 1, 2010. No refunds will be given for cancellations received after July 1, 2010.

Team Member #1: Medical Professional* Add Main Conference? Yes No

Name/Credentials _____

Job Title/Occupation _____ Organization _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ E-mail _____

Team Member #2: Mental Health Professional* Add Main Conference? Yes No

Name/Credentials _____

Job Title/Occupation _____ Organization _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ E-mail _____

Additional Team Member (optional; \$150 each; add pages as needed) Add Main Conference? Yes No

Name/Credentials _____

Job Title/Occupation _____ Organization _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ E-mail _____

GRAND TOTAL DUE (add Totals A through E) _____

(Payment in full required with registration form.)

Check Enclosed
 MasterCard VISA American Express

Account Number _____

Exp. Date _____ Verification Code _____

Name of Cardholder _____

Signature _____ Date _____

Registration confirmation with copy of invoice to follow by e-mail within 14 days of receipt.

Campus Housing Male Female
Fri Sat Sun Mon Tues Wed Thu
 (Note: Air-conditioned rooms are no longer available. Call 715.342.2969 with questions.)
Single, \$26/night Double, \$21/night/person

Roommate/Special Request _____
HOUSING TOTAL (B) _____

Campus Meals (breakfast, lunch, dinner)
Mon, \$26 Tues, \$26 Wed, \$26 Thu, \$26
Sat (lunch only), \$8.10 Sun (lunch only), \$8.10

MEALS TOTAL (C) _____

PARKING \$16/week (7/19-7/23) **(D)** _____

Continuing Education Credits, \$40/CEC provider
ACSM BOC (NATA) NBCC General
ANA/WNA NSCA NCHEC/CHES

CONTINUING EDUCATION CREDITS TOTAL (E) _____