

## 4 WAYS TO REGISTER – DON'T MISS OUT

- LOG ON:** [www.alz.org/illinois](http://www.alz.org/illinois) (See *Professional Training* tab on left sidebar)
- PHONE:** 847.933.2413 (All major credit cards accepted)
- FAX this form with credit card information to 773.444.0930**  
(complete one form per each registrant)
- MAIL this form to:** Alzheimer's Association, 8430 W. Bryn Mawr, Suite 800, Chicago, IL 60631

NAME \_\_\_\_\_

JOB TITLE \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

### Cancellation Policy

Registrants who cancel more than **7 days** prior to an event may receive a full refund. Cancellations received after that will not be eligible for a refund, but the fee may be applied to a future event or transferred to another person. Any "no shows" on the day of the event will not be eligible for a refund, nor the option to apply the fee to a future event.

### I am registering for:

<u>Program</u>	<u>Date</u>	<u>Location (city)</u>	<u>Cost</u>
Best Friends Approach to Dementia Care Train-the-Trainer	___/___/___	_____	\$250
Best Friends Approach to Dementia Care - Direct Care Staff	___/___/___	_____	\$45 x ___ or \$135
Advanced Topics in Alzheimer's Care - Direct Care Staff	___/___/___	_____	\$45 x ___ or \$135
Advanced Topics in Alzheimer's Care Train-the-Trainer	___/___/___	_____	\$160 (Full day)
Advanced Topics in Alzheimer's Care Train-the-Trainer	___/___/___	_____	\$90 (Half day)
Illinois Dementia Care	___/___/___	_____	\$90
Activity-Based Alzheimer's Care	___/___/___	_____	\$90
Dementia Care 101 - Direct Care Staff	___/___/___	_____	\$45
Seminar _____ (Provide topic title)	___/___/___	_____	\$45

**Continuing Education Units (CEUs) available for professional licensure for an additional \$10.00/program.**

**Please indicate what program(s) you are requesting CEUs for:**

- Activity-Based Alzheimer's Care   
  Advanced Topics in Alzheimer's Care (**Full-day**)  
 Advanced Topics in Alzheimer's Care (**Half-day**)   
  Best Friends   
  Illinois Dementia Care   
  **A Seminar**

Profession \_\_\_\_\_ License # \_\_\_\_\_ CEU total \$ \_\_\_\_\_

Please note any dietary restrictions: \_\_\_\_\_ Total amount \$ \_\_\_\_\_

### Please indicate payment method:

Check enclosed      Check #: \_\_\_\_\_  
Credit card

MasterCard / VISA / American Express / Discover  
(circle one)

Card number: \_\_\_\_\_

Expiration year: \_\_\_/\_\_\_

Card Holder Signature: \_\_\_\_\_

Card Holder Address, if different than above: \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip code \_\_\_\_\_