

**MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS
2018 Conference Registration Form**

****Please complete one form per attendee.**

Name: _____

Health Center: _____

Title: _____

Address: _____

City/State _____ Zip: _____

Telephone: _____ E-Mail: _____

All registrations must include the attendee name, title, organization, days attending and email address.

Choose your CHI registration type:

Rate per attendee

- | | |
|--|------------|
| <input type="checkbox"/> Full three-day registration – Wednesday, Thursday & Friday | \$775 |
| <input type="checkbox"/> Special discounted rate for 3 or more registrants attending three-full days <u>and</u> registering at the same time: | \$675 each |
| <input type="checkbox"/> Two-day registration: Wednesday & Thursday | \$675 |
| Two-day registration with Friday: | |
| <input type="checkbox"/> Wednesday & Friday OR <input type="checkbox"/> Thursday & Friday | \$650 |
| One-day registration – Choose one day | |
| <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday | \$425 |
| <input type="checkbox"/> Friday Only registration | \$295 |
| <input type="checkbox"/> Please check if you require special accommodations to fully participate. Explain below. | |

 Please check if you require special dietary accommodations to fully participate. Explain below.

Amount Enclosed _____ Check # _____

All cancellations must be in writing. Please allow 6-8 weeks following the conclusion of conference for all refunds.

Cancellations received on/before May 1, 2018 will be assessed a \$50 processing fee. Cancellations received after May 1, 2018 are non-refundable. No shows are non-refundable. To register online by credit card, go to [Click here to register](#)