

# MHCA ~ Registration / Invoice Form

To pay with a credit card, to ensure the accuracy and safety of your information, you must [register and process your payment online](#).

Please PRINT or TYPE the information below to ensure accuracy on registration material.

Facility/Organization: \_\_\_\_\_

Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

PLEASE INDICATE the seminar job code for each program(s) you would like to register for and photocopy the form as needed. *If you register more than one participant from the same facility/corporate office, after paying full price for the 1<sup>st</sup> person, a \$10 discount applies for each additional registrant from the same facility/corporate office.*

- **Registrant:**  Mr.  Ms. \_\_\_\_\_ **Title:** \_\_\_\_\_  
 Email Address: \_\_\_\_\_ **Job Code:** \_\_\_\_\_ **Fee:** \_\_\_\_\_
- **Registrant:**  Mr.  Ms. \_\_\_\_\_ **Title:** \_\_\_\_\_  
 Email Address: \_\_\_\_\_ **Job Code:** \_\_\_\_\_ **Fee:** \_\_\_\_\_
- **Registrant:**  Mr.  Ms. \_\_\_\_\_ **Title:** \_\_\_\_\_  
 Email Address: \_\_\_\_\_ **Job Code:** \_\_\_\_\_ **Fee:** \_\_\_\_\_
- **Registrant:**  Mr.  Ms. \_\_\_\_\_ **Title:** \_\_\_\_\_  
 Email Address: \_\_\_\_\_ **Job Code:** \_\_\_\_\_ **Fee:** \_\_\_\_\_

**TOTAL:** \_\_\_\_\_

Job Code	Location	General Seminar Title	CEUs	MHCA Member Rates	Non-Member Rates
W20092	Web-Based Series (via Zoom)	Assessing Psychosocial Well-Being: Empowering Social Workers & Impacting Residents' Lives (September 23 & 24, 2020)	4	\$99 1 <sup>st</sup> Registrant \$89 Additional	\$149 1 <sup>st</sup> Registrant \$139 Additional

## PAYMENT METHOD:

Payment is required at the time of registration or at least one week prior to the program. Acceptable forms of payment include cash, checks and credit cards. If you opt to pay with a credit card, you must [register and process your payment online](#). If you prefer an alternative payment option, please indicate your payment method below:

Check/Cash Attached.

Check Requested from Facility. Please include date requested \_\_\_\_/\_\_\_\_/\_\_\_\_.

Then, fax your completed registration to MHCA at **207-623-4080** AND mail the original (with your payment), to:

Maine Health Care Association  
 317 State Street  
 Augusta, ME 04330.