

ARN 35th Annual Education Conference

When two or more ARN members from one facility register for the conference, each registrant is eligible for this discounted rate. To qualify, all team members must be registered at the same time using the team member discount registration form. **NOTE: A minimum of two members must be included on this registration form.** Please note that ARN membership is required.

For office use only	
Cust # _____	Mtg Ord # 3- _____
Date _____	

Team member #1 (required)

Complete name		First name for badge
<input type="checkbox"/> Check here if this is your first ARN conference (FTA)		
Facility		Facility city/state
Mailing address	Home	Work
City/state/zip		Country
Work phone	Fax	Home phone
E-mail (required to receive confirmation of registration)		
In case of emergency during the meeting, contact:		
Daytime phone		Evening phone

SPECIAL REQUESTS

- (DIS) I do not wish to have my name and contact information included in the on-site attendee list.
- (SDV) I will need a vegetarian meal
- (SA) I will be using a wheelchair at the conference
 (Information needed to project space accommodations for meeting rooms and other functions.)

Team member #1 registration fee

- Received on or before 9/14/09 (MD) \$435
- Received on or after 9/15/09 (MD) \$535
- ARN membership (Required: if you are not already a member, please include this amount in the subtotal.) \$110
- Registration Fee Subtotal: \$ _____**

Monday, October 19–Tuesday, October 20

- (LC) Leadership Course \$195
- Subtotal: \$ _____**

Preconference Sessions - Wednesday, October 21

- (001) Wound Care Update (8:30 am - Noon) \$95
- (002) Panel: Returning Heroes (8:30 am - Noon) \$95
- (003) Documenting Rehabilitation Nursing Interventions (1:30 - 4:30 pm) \$95

Preconference Workshop Subtotal: \$ _____

Session Registration

The following concurrent sessions are included with your registration. Please enter the 3-digit number for each session you plan to attend. (See Schedule of Events for session codes.)

Thursday 11 am–Noon	<table border="1" style="border-collapse: collapse; width: 80px;"> <tr><td style="width: 20px; text-align: center;">2</td><td style="width: 20px; text-align: center;">0</td><td style="width: 20px; text-align: center;"> </td></tr> </table>	2	0		
2	0				
Thursday 1:30–2:30 pm	<table border="1" style="border-collapse: collapse; width: 80px;"> <tr><td style="width: 20px; text-align: center;">3</td><td style="width: 20px; text-align: center;">0</td><td style="width: 20px; text-align: center;"> </td></tr> </table>	3	0		Friday, 1:30–2:30 pm
3	0				
Friday 11:30 am–12:30 pm	<table border="1" style="border-collapse: collapse; width: 80px;"> <tr><td style="width: 20px; text-align: center;">4</td><td style="width: 20px; text-align: center;">0</td><td style="width: 20px; text-align: center;"> </td></tr> </table>	4	0		Saturday 2–3 pm
4	0				

5	0	
5	0	

Optional Events

THURSDAY, OCTOBER 22

(RNF) RNF Benefit Dinner at El Pinto Restaurant (6:30–9:30 pm)
\$110 per ticket, # of tickets: _____ \$ _____

FRIDAY, OCTOBER 23

(WW) Wake Up and Walk (6:15–7:15 am)
\$10 per ticket, # of tickets: _____ \$ _____

(AR) Anniversary Reception (6–8:30 pm)
FREE, # of Tickets: _____

(OE1) Walking Ghost Tour (following the anniversary reception)
FREE, # of tickets: _____

Optional Event Subtotal: \$ _____

Guest Passes

(GST) \$65 per ticket, # of tickets: _____ **Guest Pass Subtotal: \$ _____**

Guest name: _____

Guest name: _____

(See conference brochure, page 7, for description)

Please accept my tax-deductible contribution to support rehabilitation nursing research.

\$ _____

Team member #1 total fees: \$ _____

Team member #2 (required)

Complete name

First name for badge

Check here if this is your first ARN conference (FTA)

Facility

Facility city/state

Mailing address

Home

Work

City/state/zip

Country

Work phone

Fax

Home phone

E-mail (required to receive confirmation of registration)

In case of emergency during the meeting, contact: _____

Daytime phone

Evening phone

SPECIAL REQUESTS

(DIS) I do not wish to have my name and contact information included in the on-site attendee list.

(SDV) I will need a vegetarian meal

(SA) I will be using a wheelchair at the conference

(Information needed to project space accommodations for meeting rooms and other functions.)

Team member #2 registration fee

Received on or before 9/14/09 (MD) \$435
Received on or after 9/15/09 (MD) \$535

ARN membership (Required: if you are not already a member,
please include this amount in the subtotal.) \$110

Registration Fee Subtotal: \$ _____

Monday, October 19–Tuesday, October 20

(LC) Leadership Course \$195

Subtotal: \$ _____

Preconference Sessions - Wednesday, October 21

(001) Wound Care Update (8:30 am - Noon) \$95
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Thursday 11 am–Noon

2	0	
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Friday, 1:30-2:30 pm

5	0	
---	---	--

Thursday 1:30–2:30 pm

3	0	
---	---	--

Saturday 2–3 pm

5	0	
---	---	--

Friday 11:30 am–12:30 pm

4	0	
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Optional Events

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Optional Event Subtotal: \$ _____

Guest Passes

(GST) \$65 per ticket, # of tickets: _____ **Guest Pass Subtotal: \$ _____**

Guest name: _____

Guest name: _____

(See conference brochure, page 7, for description)

Please accept my tax-deductible contribution to support rehabilitation nursing research.

\$ _____

Team member #2 total fees: \$ _____

Team member #3 (optional)

Complete name		First name for badge
<input type="checkbox"/> Check here if this is your first ARN conference (FTA)		
Facility		Facility city/state
Mailing address	Home	Work
City/state/zip		Country
Work phone	Fax	Home phone
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Team member #3 registration fee

- Received on or before 9/14/09 (MD) \$435
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- ARN membership (Required: if you are not already a member, please include this amount in the subtotal.) \$110
- Registration Fee Subtotal: \$ _____**

Monday, October 19–Tuesday, October 20

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- Subtotal: \$ _____**

Preconference Sessions - Wednesday, October 21

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Optional Events

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(AR) Anniversary Reception (6-8:30 pm)
FREE, # of Tickets: _____

(OE1) Walking Ghost Tour (following the anniversary reception)
FREE, # of tickets: _____

Optional Event Subtotal: \$ _____

Guest Passes

(GST) \$65 per ticket, # of tickets: _____ **Guest Pass Subtotal: \$ _____**
Guest name: _____
Guest name: _____
(See conference brochure, page 4, for description)

Please accept my tax-deductible contribution to support rehabilitation nursing research. \$ _____

Team member #3 total fees: \$ _____

Total registration fees: \$ _____
(Total of team members' 1-3 fees)

PAYMENT INFORMATION

Check # _____  MasterCard  VISA  American Express  Discover
(Enclosed)

- Make check payable to ARN in US funds.
- A charge of \$25 will apply to checks returned for insufficient funds.
- If rebilling of a credit card is necessary, a \$25 processing fee will be charged.
- I authorize ARN to charge the credit card(s) listed amounts reasonably deemed by ARN to be accurate and appropriate.

Account number _____

Expiration date _____

Signature _____

Cardholder's name (Please print) _____

Full payment must accompany this form in order for the registrations to be processed.

2 easy ways to register

Mail

SEND THIS REGISTRATION FORM WITH PAYMENT TO
ARN Conference
PO Box 839
Glenview, IL 60025-0839

Phone

Call ARN at 800/229-7530 or 847/375-4710 (credit card payment only). Sorry, online registration is not available for team member discount registration.

CANCELLATION POLICY

All cancellations must be made in writing. A \$100 processing charge will apply to all cancellations. No refunds will be made on cancellations postmarked after September 21, 2009. All refunds will be processed after the conference.

ARN reserves the right to substitute faculty or to cancel or reschedule sessions due to low enrollment or other unforeseen circumstances. If ARN must cancel, registrants will receive full credits or refunds of their paid registration fees. No refunds can be made for lodging, airfare, or any other expenses related to attending the conference.