



American
Medical
Rehabilitation
Providers
Association

AMRPA SPRING MEETING
The Ritz Carlton Pentagon City
1250 South Hayes Street
Arlington, VA 22202
(703) 415-5000

REGISTRATION FORM

NAME: _____ TITLE: _____

FACILITY NAME (IF DIFFERENT THAN ABOVE): _____

MEDICARE PROVIDER NUMBER _____

ADDRESS: _____
(PLEASE GIVE ADDRESS OF YOUR PHYSICAL LOCATION)

CITY, STATE, ZIP: _____

PHONE: _____

FAX: _____

EMAIL: _____

PLEASE REPRODUCE THIS FORM FOR ADDITIONAL REGISTRANTS

ALL REGISTRATIONS ARE ON A FIRST-COME FIRST SERVE BASIS, SPACE IS LIMITED.
REGISTRATION DEADLINE – February 4, 2009

MEMBER FEE: \$250 Prior to January 15, 2009; \$295 after January 15, 2009

NON-MEMBER FEE: \$395 Prior to January 15, 2009; \$395 after January 15, 2009

METHOD OF PAYMENT:

- CHECK ENCLOSED (Make checks payable to AMRPA.)
- Please bill me at the above address unless otherwise noted.
- Master Card/Visa accepted.

Type of credit card _____ Cardholder Name _____

Card number _____ Expiration Date _____

Please indicate if you have special needs and/or special diet.

Special Needs: _____

3 easy ways to register - by fax, by email, by mail.

Phone: (217) 753-1190 Fax: (217) 525-1271 Email: acheatham@hso.net Mail: 206 S. 6th,
Springfield, IL 62701 (to obtain additional registration forms visit www.amrpa.org)

(50% CANCELLATION FEE ASSESSED AFTER FEBRUARY 4, 2009)

If you have questions, please contact AMY CHEATHAM(acheatham@firminc.com) or VICKI WILTSIE (vwiltsie@firminc.com) at (217)753-1190.