

<p>Registration Form</p> <p><i>(Photocopies may be used)</i></p> <p>The Wisconsin Health Care Employee Pride Program</p> <p><i>Thurs., May 7, 2009, Kalahari Resort, WI Dells</i></p>	<p><i>Mail or fax your completed registration form with payment to:</i></p> <p>WHA, Attn: Education P.O. Box 259038 Madison, WI 53725-9038 Fax: 608-274-8554</p> <p>Return this form to WHA by April 24, 2009</p>
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Hospital Contact Person for Pride Program _____

Facility _____

Address _____

City/State/Zip _____

Contact Person Email _____ Phone _____

Complimentary Registrations (Two registrations at no cost)

Honored Employee Name _____ Title _____

Hospital Representative _____ Title _____

We will not be attending the May 7 reception and dinner.

Guest Registrations (Additional guests: Adults \$40 each / Children \$10 each)

Name _____	<input type="checkbox"/> Adult	<input type="checkbox"/> Child	<input type="checkbox"/> Vegetarian
Name _____	<input type="checkbox"/> Adult	<input type="checkbox"/> Child	<input type="checkbox"/> Vegetarian
Name _____	<input type="checkbox"/> Adult	<input type="checkbox"/> Child	<input type="checkbox"/> Vegetarian
Name _____	<input type="checkbox"/> Adult	<input type="checkbox"/> Child	<input type="checkbox"/> Vegetarian
Name _____	<input type="checkbox"/> Adult	<input type="checkbox"/> Child	<input type="checkbox"/> Vegetarian

Payment Information

Check Total Enclosed: \$ _____ *(Make checks payable to: Wisconsin Hospital Association)*

Visa MasterCard Name on card _____

Billing Address (for name on card) _____

City/State/Zip (for name on card) _____

16 Digit Number _____

Expiration Date _____ Amount \$ _____