Attendee Registration Form

Registration Form (to be used for registrations by mail)

Select your track:
___ Acute Care
___ Caring for People with Developmental Disabilities or Mental Health Disorders
___ Long Term Care and Sub Acute Care

Mail this completed registration form and the registration fee to:
Safe Patient Handling Conference c/o AREEP PO Box 38195 Albany, NY 12203

Please type or clearly print. **All information is required.**
Enter the information exactly as you want it to appear on your nametag.

**Attendee’s Name:** ____________________________

**Employer Name:** ____________________________________________

**Job Title:** ____________________________________________

**Employer’s Mailing Address:** ____________________________________________

**Attendee’s Daytime Phone (include area code):** (________)______________________

**Attendee’s E-Mail:** ____________________________

**Please provide an email address you check regularly, as information and instructions will be emailed prior to and following the conference.**

**Affiliation if applicable:**
__ CSEA __ PEF __ NYSNA __ NYCOSH __ 1199 SEIU __ M/C
__ DC37 __ NYSUT __ CNFNY __ COSH Group __ CWA __ NYS AFL-CIO __ None
__ Other: ____________________________________________

Check type of Continuing Education Credits needed:
___ Occupational Therapy Professional License number________________
___ Nursing Home Administrator Professional License Number ______________
___ Physical Therapy Professional License Number ______________
___ Nursing
___ Industrial Hygiene
___ Other
___ I do not wish to receive continuing education credits

It is the intent of the conference organizers to provide a fully accessible learning environment, suitable for all learners. If you have any special needs please let us know and you will be contacted by conference organizers.
___ yes ___ no

For more information, contact Maureen Cox at 518 281 6575 or maureencox12@gmail.com or Barbara Stanley at 716 725 9858 or brbrstanley0903@gmail.com.