Clinical Health Coach®
Transform the Conversation. Transform the Care.™

Registrant Information – Training Dates: Feb. 26-28, 2014 and March 26-27, 2014

Please submit information as you would wish it to appear on your name badge:

_____ First Name

_____ Last Name

_____ Credentials (ex. RN)

_____ Job Title

_____ Organization (Please spell out full name)

_____ Mailing Address: ( ) Work ( ) Personal

_____ Phone: ( ) Work ( ) Personal

_____ City/ State/ Zip Code

_____ Email: ( ) Work ( ) Personal

_____ FAX

MARK IF CEU'S REQUESTED:

- ☐ AMA PRA Category I Credits ™
- ☐ Nursing- Iowa Board of Nursing
- ☐ Registered Dietitian

MARK FOR SPECIAL ACCOMMODATIONS:

- ☐ Dietary _____
- ☐ Physical _____
- ☐ Other _____

HOW DID YOU HEAR ABOUT THE PROGRAM?

- ☐ Emailed fliers/information
- ☐ ICCC Faculty
- ☐ Friend/Colleague
- ☐ Social Media (Facebook, Twitter, LinkedIn)
- ☐ Website/Google
- ☐ Conferences
- ☐ Other _____

WHICH BEST DESCRIBES YOUR HEALTHCARE SETTING:

- ☐ Hospital-based
- ☐ Clinic-based
- ☐ Community-based

Registration Fees

- ☐ **Through December 31, 2013 - $1500.00/person**
- ☐ **January 1, 2014 through February 19, 2014 - $1600.00/person**
  For registration beyond February 19th, please call 515-661-6231 to check on space availability

Group Registration Discount

Two or more registrations submitted at the same time from the same organization receive an additional $50.00 /person discount.

Competency Evaluation ***

- ☐ **Evaluation Fee -** $195.00/person

Total Number of Evaluations from your organization: _____

Total Payment Amount _____ **Total Number of Registrants** _____

*** Competency Evaluation

Successful completion of this telephonic-based evaluation, combined with a score of at least 70% on the written exam, culminates in the participant receiving a Certificate of Competency in Clinical Health Coaching as offered through the Iowa Chronic Care Consortium. All evaluations will be scheduled upon completion of the Clinical Health Coach Training Program.

If more than one evaluation is involved, please list the names of the additional participants: _____

_____

Payment Methods

Payment is accepted by check or money order only. Registration form may be mailed or emailed to hold a place, with payment to follow within 10 days. Regular registration payment must be received no later than 2/19/14. Checks must be postmarked no later than 12/31/13 in order to receive the Early Bird registration discount.
**Please refer to website at www.iowaccc.com for cancellation policy.*

- ☐ PAY WITH CHECK
- ☐ PAY WITH MONEY ORDER
- ☐ AMOUNT ENCLOSED $ _____

MAKE CHECKS PAYABLE TO:
Iowa Chronic Care Consortium
5550 Wild Rose Lane, Suite 400
West Des Moines, IA 50266

SCAN AND EMAIL REGISTRATION TO:
amy.finstad@iowaccc.com

ADDITIONAL REGISTRANT INFORMATION *Please submit as you would like it to appear on your name badge*

_____ First Name

_____ Last Name

_____ Credentials (ex. RN)

_____ Title

_____ Organization (Please spell out full name)

_____ Mailing Address: ( ) Work ( ) Personal

_____ Phone: ( ) Work ( ) Personal

_____ City/ State/ Zip Code

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- ☐ Other _____

****** For multiple registrations make additional copies of this page***