Check and Interdepartmental Fund Transfer Registration Form *(Please photocopy as needed)*

charlotte ahec area health education center

MAIL TO:
CHARLOTTE AHEC REGISTRAR
P.O. Box 32861, CHARLOTTE, NC 28232-2861

FAX TO: 704.512.6062
All Credit Card Payments:
REGISTER ONLINE AT:
www.charlotteahec.org

Participant Information

Last Name _____ First Name _____ MI _____ ◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms.

Nickname _____ Last Four Digits of SSN *(required)* _____ Race (optional) _____ ◯ Male ◯ Female

Degree / Certification / License _____ Employer and Department _____ Specialty _____

Employer County _____ Home Address *(Street / P.O. Box, City, State, Zip)* _____

Preferred Mailing Address: ◯ Home ◯ Office

Work Address *(Street / P.O. Box, City, State, Zip)* _____

Home Phone _____ Work Phone _____ Fax _____ Email _____

Disclaimer: By providing your fax number, email address and telephone number, you have granted permission for us to contact you via the numbers and address indicated. Would you like your name removed from our mailing list? ◯ Yes ◯ No

List the program(s) that you would like to attend:

Program Title	Event #	Program Date(s)	Fee
	Total Amount for Program(s)		

Meal Preference and Billing Information:

Please indicate if you would like a vegetarian meal: ◯ **Yes** ◯ **No**

Payment Methods: **ALL CREDIT CARD PAYMENTS MUST REGISTER ONLINE AT: *www.charlotteahec.org***

◯ Check:

Payor Name-_____

Check Number- _____ Amount- _____

◯ Interdepartmental Transfer of Funds: (Carolinas HealthCare System Employees Only)

Department Name: _____ BU# ___ ___ ___ ___ Dept. # ___ ___ ___ ___ ___ ___

Additional Details:_____