

REGISTRATION FORM

MIDWEST FARMWORKER STREAM FORUM
November 6-8, 2003

First Name:		Last Name:	
Title:		Credentials:	
Organization Name:			
Address:	City:	State:	Zip:
Email:			
Phone:		Fax:	

To better meet your needs, please tell us what days you plan to attend the conference?

(Check all that apply) Diabetes Pre-Conference Training Cultural Competency Full Day Workshop
 Thursday Friday Special Event Film Screening Saturday Evening Dinner Reception

What specific topics or training would you like to see offered at the conference?

How did you hear about the conference? _____

Inclusive of this year's conference, how many Migrant Stream Forums have you attended? First one Second 3 +

How many years have you been involved in Farmworker Health?

< 1 1-3 yrs. 4-6 yrs. 7 – 10 yrs. > 10 yrs.

Select the category that best describes your primary occupation:

- | | |
|---|---|
| <input type="checkbox"/> Allied Health Provider | <input type="checkbox"/> Medical Director |
| <input type="checkbox"/> Board Member | <input type="checkbox"/> Migrant Education Representative |
| <input type="checkbox"/> Clinical Director/Mgr. | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Dental Director | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Executive Director | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Farmworker | <input type="checkbox"/> Student |
| <input type="checkbox"/> Health Educator | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Lay Health Worker | <input type="checkbox"/> State/Federal Employee |
| <input type="checkbox"/> M/CHC Board Member | <input type="checkbox"/> Other _____ |

Registration Fee..... **\$125** _____
 After Oct. 6, add additional charge **\$25** _____
 Cultural Competency Full Day Workshop **\$25** _____
 Saturday Reception Guest Ticket..... **\$30** _____
TOTAL DUE \$ _____

MAIL OR FAX REGISTRATION FORM WITH PAYMENT TO:

Forum Registration **512-312-2600 FAX**
 NCFH, Inc.
 1770 FM 967
 Buda, TX. 78610

____ Check enclosed, Check # _____

____ VISA ____ MasterCard ____ AMEX

 Credit Card Number Expiration Date

 Billing Address

 Print Name of Person on Card

 Print Name of Company on Card (if applicable)

 Cardholder Signature