

**REGISTRATION FORM - 19<sup>th</sup> Annual Midwest Stream Farmworker Health Forum, November 18-21, 2009**

**ATTENDEE INFORMATION**

Name \_\_\_\_\_  
 Title \_\_\_\_\_  
 Organization \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Select the category that best describes your primary occupation.**

- |  |   |
|--|---|
| <input type="checkbox"/> Administrative Staff          | <input type="checkbox"/> Migrant Director       |
| <input type="checkbox"/> Allied Health Provider        | <input type="checkbox"/> Migrant Education Rep. |
| <input type="checkbox"/> Board Member                  | <input type="checkbox"/> Nurse                  |
| <input type="checkbox"/> Clinical Director/Mgr.        | <input type="checkbox"/> Nurse Practitioner     |
| <input type="checkbox"/> Consultant                    | <input type="checkbox"/> Physician              |
| <input type="checkbox"/> Dental                        | <input type="checkbox"/> Physician Assistant    |
| <input type="checkbox"/> Executive Director/CEO        | <input type="checkbox"/> Program Coordinator    |
| <input type="checkbox"/> Farmworker                    | <input type="checkbox"/> Program Director       |
| <input type="checkbox"/> Health Educator               | <input type="checkbox"/> Researcher             |
| <input type="checkbox"/> Lay Health Worker/Promotor(a) | <input type="checkbox"/> Social Worker          |
| <input type="checkbox"/> M/CHC Board Member            | <input type="checkbox"/> State/Federal Employee |
| <input type="checkbox"/> Medical Director              | <input type="checkbox"/> Student                |
| <input type="checkbox"/> Medical Nursing Assistant     | <input type="checkbox"/> Other _____            |

**Please complete the following information:**

- Inclusive of this year's conference, how many Migrant Stream Forums have you attended?  
 \_\_\_ First one \_\_\_ Second time \_\_\_ 3+
- How many years have you been involved in Farmworker Health?  
 \_\_\_ <1 \_\_\_ 1-3yrs \_\_\_ 4-6yrs \_\_\_ 7-10yrs \_\_\_ >10yrs
- How did you hear about this conference? \_\_\_ web \_\_\_ e-mail \_\_\_ Newsline Newsletter \_\_\_ colleague \_\_\_ regular mail \_\_\_ other: \_\_\_\_\_
- Do you have any special needs? (*Ex. vegetarian meals*)  
 \_\_\_\_\_
- Interpretation Services: ¿Necesita interpretación en Español para las presentaciones en Ingles?  
 \_\_\_\_\_ Si \_\_\_\_\_ No

**PAYMENT**

<b>Early Bird Fee:</b> Register by October 20 <sup>th</sup> .....	\$275	\$ _____
<b>Standard Fee:</b> Register after October 20 <sup>th</sup> .....	\$325	\$ _____
<b>One Day Registration Fee</b> .....	\$200	\$ _____
<b>Additional Guest - Friday Dinner Ticket</b> .....	\$25	\$ _____
I would like to donate to the <i>Call for Health Program</i> (An information and referral toll-free phone line for farmworkers)		\$ _____
<b>TOTAL</b>		\$ _____

**TOTAL**

**RESERVATION INFORMATION**

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**HOTEL**  
**Isla Grand Beach Resort**  
**South Padre Island, Texas**

**Rate: \$95 Single/Double Cabanas**  
**\$180 Condos**

Call Hotel Reservations at:  
**800-292-7704**

Refer to group:  
**“National Center for Farmworker Health Forum”**

*Special conference rates will be offered until*  
**October 20<sup>th</sup>**

**Rooms are Limited**  
 For more information,  
 please contact Monica S. at:  
**saavedra@ncfh.org**  
 or call (512) 312-5468

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**Every 3<sup>rd</sup> registrant qualifies for a FREE registration with 2 paid registrations.**

I qualify as the 3<sup>rd</sup> registrant. (ALL registrations must be from the same organization and ALL registrations must be submitted at one time.)

**CALL** Toll Free (800) 531-5120  
**FAX** to (512) 312-2600  
**MAIL** to: NCFH, Inc. 1770 FM 967, Buda, TX 78610

**Cancellation:** If you cannot attend, you may send a substitute. Full refunds will only be provided if cancellation is prior to **November 4<sup>th</sup>**. No refunds provided after **November 4<sup>th</sup>**.

**Method of Payment:** (NCFH, FED ID #74-1826899)

Check made out to NCFH, Inc. is enclosed. Check no. \_\_\_\_\_  
 A purchase order is attached (*government, educational and health care organizations only*)  
 Charge to:  Master Card  Visa  American Express

Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 Print Name of Person on Card \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Billing Address \_\_\_\_\_

**FOR NCFH USE ONLY**

Date Received \_\_\_\_\_  
 Payment Amt. Enclosed \_\_\_\_\_  
 Check  Purchase Order  Credit Card