Use this form to register online.

Name: ___________________________________________ Degree(s): ____________________________

Job Title: ______________________________________ Place of Work: __________________________

Mailing Address: _______________________________________________________________________

City: __________________________________________ State: _______ Zip: __________________________

Phone: ______________________________ Fax: ____________________________________________

Mobile: ______________________________________ Email: ___________________________________

REGISTRATION

Which best describes your role?  □ Physician/Nurse/Clinical Staff/Medical Director □ Health Administrator

REGISTRATION FEES

<table>
<thead>
<tr>
<th>Description</th>
<th>Through 6/30</th>
<th>After 6/30</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correctional Health Care Leadership Institutes only</td>
<td>□ $425</td>
<td>□ $525</td>
<td>$______</td>
</tr>
<tr>
<td>Combined Registration: Mental Health Care and Leadership Institutes</td>
<td>□ $650</td>
<td>□ $750</td>
<td>$______</td>
</tr>
</tbody>
</table>
| Conference Discount ($25) for new or current CCHPs             | □ Less $25  | □ Less $25 | ($______)

OPTIONAL MEMBERSHIP OFFERS (These organizations are independent of NCCHC)

American College of Correctional Physicians (www.accpmed.org)
Join ACCP  Regular member (Physician) □ $150  Affiliate member (DDS, PA or NP) □ $100  $______

Academy of Correctional Health Professionals (www.correctionalhealth.org)
Join Academy  Regular member □ $75  CCHP □ $50  $______

Conference Discount ($25) for new or current members of ACCP or the Academy  □ Less $25 ($______)

Billing Fee* (if applicable)  □ $30  $______

PAYMENT INFORMATION  FEIN 36-3221830

□ Enclosed is my check payable to the National Commission on Correctional Health Care (NCCHC).

Please bill my □ MasterCard  □ Visa  □ American Express □ Discover

Card #: ___________________________________________ Expires: ____________________

Signature (for credit card payment only): _____________________________________________

Billing Address (if different from above): _______________________________________________________________________

Signature: ___________________________________________ Date: ______________________

□ *Please invoice my facility. Purchase orders accepted only from government agencies and their contractors. Purchase order must accompany registration form. There is a $30 service charge for invoice processing.

Return this registration form, along with payment, to:

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE
PO Box 6233, Carol Stream, Illinois 60197-6233
Phone: 773-880-1460 • Fax: 773-880-2424
email: info@ncchc.org • www.ncchc.org

FOR OFFICE USE ONLY

Use this form or click here to register online