WAKE AHEC
PART OF NC AHEC

RECRUIT
TRAIN
RETAIN

Each participant will need a MyAHEC account. Please provide the email address associated with each participant's account.

Multiple Participant Registration Form

(Please print.)

Program Name: _____ **Program Date:** _____

1

Preferred Email: _____**(REQUIRED)** **☐Dr. ☐Mr. ☐Ms. ☐Mrs.**

First Name : _____ MI: _____ Last: _____

Clinical Specialty: _____ Degree(s) (e.g., MD, PharmD, MS, BS): _____

2

Preferred Email: _____**(REQUIRED)** **☐Dr. ☐Mr. ☐Ms. ☐Mrs.**

First Name : _____ MI: _____ Last: _____

Clinical Specialty: _____ Degree(s) (e.g., MD, PharmD, MS, BS): _____

3

Preferred Email: _____**(REQUIRED)** **☐Dr. ☐Mr. ☐Ms. ☐Mrs.**

First Name : _____ MI: _____ Last: _____

Clinical Specialty: _____ Degree(s) (e.g., MD, PharmD, MS, BS): _____

4

Preferred Email: _____**(REQUIRED)** **☐Dr. ☐Mr. ☐Ms. ☐Mrs.**

First Name : _____ MI: _____ Last: _____

Clinical Specialty: _____ Degree(s) (e.g., MD, PharmD, MS, BS): _____

_____
Employer

_____
Work Address City

_____
State Zip Work Fax Work Phone

_____
Department

By providing fax number, email addresses and telephone number, you have granted permission for us to contact those listed above via the numbers and addresses indicated.

Payment Options **Payment of check, credit card or supervisor signature must accompany registration.**

☐ Check enclosed. (Make check payable to Wake AHEC.)

☐ Credit Card: *Please call 919-350-8547 and ask for the project coordinator associated with this program in order to provide credit card information.*

☐ Employer will make payment. Supervisor to complete below. Scan form and email to wakeahecinfo@wakeahec.org.

_____
Supervisor's Name (Printed) (Signature) Phone

By signing, I am certifying that agency payment will follow. If you have a balance due and do not attend or send a substitute, you will be invoiced for the full program fee.