

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: _____

	Preferred Email: _____ (REQUIRED)	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
1	First Name : _____ MI: _____ Last: _____	
	Clinical Specialty: _____ Degree(s) (e.g., MD, PharmD, MS, BS): _____	
	Preferred Email: _____ (REQUIRED)	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
2	First Name : _____ MI: _____ Last: _____	
	Clinical Specialty: _____ Degree(s) (e.g., MD, PharmD, MS, BS): _____	
	Preferred Email: _____ (REQUIRED)	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
3	First Name : _____ MI: _____ Last: _____	
	Clinical Specialty: _____ Degree(s) (e.g., MD, PharmD, MS, BS): _____	
	Preferred Email: _____ (REQUIRED)	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
4	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 and fax registration to 919-350-0470.

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.

WakeMed Employees Only:
An Education, Meeting & Travel Request Form must be submitted with the registration for processing if your department is paying.

Register online today! www.wakeahec.org
Fax: 919-350-0470
Mail: Wake AHEC
3261 Atlantic Avenue, Suite 212
Raleigh, NC 27604-1657

Questions? Please call us at 919-350-8547.
Wake AHEC is part of the North Carolina AHEC Program.