

# Engage Your Patients ON A **WHOLE NEW LEVEL**

## Clinical Health Coach® Training Program February - March, 2012 • Denver, Colorado

### Registrant Information

Please fill out form as you would like your name tag to read.

_____ FIRST NAME	_____ LAST NAME
_____ CREDENTIALS (e.g. RN)	_____ TITLE
_____ ORGANIZATION	_____ MAILING ADDRESS
_____ PHONE	_____ CITY/STATE/ZIP
_____ EMAIL    ___WORK    ___PERSONAL	_____ FAX

#### MARK IF CEUs REQUESTED:

- Nursing-Iowa                       Pharmacy  
 Nursing-Outside Iowa            Registered Dietitian

#### MARK FOR SPECIAL ACCOMMODATIONS: (please list)

- Dietary \_\_\_\_\_  
 Physical \_\_\_\_\_  
 Other \_\_\_\_\_

#### HOW DID YOU HEAR ABOUT THE PROGRAM?

- Mailed Information     Emailed Fliers     Presentations     Conferences (list) \_\_\_\_\_  
 ICCC Faculty     Friend/Colleague     Website/Google     Other \_\_\_\_\_

#### WHICH BEST DESCRIBES YOUR HEALTHCARE SETTING?

- Hospital-based     Clinic-based     Community-based

### Registration Fees\*

#### PROGRAM:

- Individual  
 2 or more individuals from one organization

(Postmarked or faxed)

#### BEFORE 1/13/12

- \$1,200.00  
 \$1,100.00 each

#### 1/13/12 – 1/30/12\*

- \$1,400.00  
 \$1,300.00 each

TOTAL NUMBER OF REGISTRANTS: \_\_\_\_\_ TOTAL PAYMENT AMOUNT: \_\_\_\_\_

If more than one registrant is involved, please use the second page of this form for the additional information.

### Competency Evaluation

Successful completion of this telephonic-based evaluation, combined with a score of at least 75% on the written exam, culminates in the participant receiving a Certificate of Competency as a Clinical Health Coach® as offered through the Iowa Chronic Care Consortium. All evaluations will be scheduled upon completion of the Clinical Health Coach® Training Program.

EVALUATION FEE:  \$195.00 each                      TOTAL NUMBER OF EVALUATIONS: \_\_\_\_\_

If more than one evaluation is involved, please list the names of the additional participants: \_\_\_\_\_

\_\_\_\_\_

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### Payment Methods

Payment is accepted by check or money order only. Registration may be faxed to hold a place, with payment to follow within 10 days. Regular registration payment must be received no later than 2/10/12. Checks must be postmarked no later than 1/13/12 in order to receive the Early Bird registration discount.

**PAY WITH CHECK**

**AMOUNT ENCLOSED \$ \_\_\_\_\_**

**PAY WITH MONEY ORDER**

**FAX REGISTRATION** (Payment to come)

*Make checks payable to:*

**Iowa Chronic Care Consortium  
5550 Wild Rose Lane, Suite 400  
West Des Moines, IA 50266**

*Fax to:*

**Iowa Chronic Care Consortium  
Attn: Kathy Kunath, (515) 661-6101**

\*Space is limited. Completed registrations will be accepted in the order that they are received. To be considered complete, all forms must be fully filled out and payment collected. Registrants will be emailed a confirmation notice and receipt. Please contact ICCC to check program availability, if sending payment after 1/30/12. For multiple registrations, payment and registration forms must be sent together to receive the discount.

### Additional Registrant Information Fields

#### Registrant Information

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FIRST NAME \_\_\_\_\_

LAST NAME \_\_\_\_\_

CREDENTIALS (e.g. RN) \_\_\_\_\_

TITLE \_\_\_\_\_

ORGANIZATION \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

EMAIL  WORK  PERSONAL \_\_\_\_\_

FAX \_\_\_\_\_

#### MARK IF CEUs REQUESTED:

Nursing-Iowa

Pharmacy

Nursing-Outside Iowa

Registered Dietitian

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Dietary \_\_\_\_\_

Physical \_\_\_\_\_

Other \_\_\_\_\_

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LAST NAME \_\_\_\_\_

CREDENTIALS (e.g. RN) \_\_\_\_\_

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ORGANIZATION \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

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EMAIL  WORK  PERSONAL \_\_\_\_\_

FAX \_\_\_\_\_

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