# REGISTRATION FORM

HopeWell CANCER SUPPORT

15th Annual Conference for Cancer Care Professionals

## Decision-Making in Cancer Care: Helping Patients Make the Crucial Choices

### COST

$50.00 per person (includes continental breakfast)
A confirmation email will be sent upon receipt of registration and payment.
Payment is due by Friday, October 20, 2017.

NAME *(include prefix, credentials)*

_____

ADDRESS _____

CITY_____STATE _____ ZIP _____

PHONE _____

FAX _____

EMAIL _____

EMPLOYER _____

POSITION _____

### TO PAY BY CHECK

Return the registration form along with a check payable to HopeWell Cancer Support.
Our address is P.O. Box 755, Brooklandville, MD 21022.

*If paying by check, please include check number here:* _____

### TO PAY BY CREDIT CARD

☐ Please bill my credit card. *(Circle one)* VISA MASTERCARD AMEX

Name as it appears on card _____

Card # ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date ____ /_____ CVV _____

Signature / Date: _____ _____

FOR MORE INFORMATION, AND/OR TO REGISTER OR PAY BY PHONE, PLEASE CALL 410.832.2719.