

Integrating Ethical Reflection into Practice

Health Care Ethics Seminar

REGISTRATION FORM

Contact Information

Name: _____

Institution/Specialty: _____

Address: _____

City: _____ Province/State: _____

Postal Code/ZIP: _____ Phone: (____) _____

Email: _____

Special Needs: _____

Course Fee: \$800 Canadian per person*

**This includes tuition, electronic course materials, Monday's snack and reception, Wednesday's dinner and break refreshments*

Payment Information

check is enclosed (*payable to Providence Health Care*)

Credit Card (*select one*)

Visa Master Card American Express

Name of Cardholder (as it appears on the card):

Signature (required): _____

Card #: _____ Expiry date (*month/year*): _____

Cancellation Refund: \$500 before March 2; \$250 before March 11; no refund after March 11

Mail or fax Registration Form to:

Providence Health Care Ethics Services

1081 Burrard Street,

Vancouver, BC, V6Z 1Y6

Telephone: (604) 806-9952

Fax: (604)806-9071

Email: jmonthatawil@providencehealth.bc.ca