

RISKY CHOICES – RISKY BEHAVIOURS

REGISTRATION FORM

Fee \$100.^{00*}

(*The fee includes breakfast and lunch)

PHC Staff/Physicians FREE

Name: _____

Address: _____

Phone: _____ **Email:** _____

Method of Payment:

Cheque (payable to Providence Health Care)

Visa Mastercard

Amex

Credit Card # **Exp. Date**

Signature

Cancellations received on or before 19 April will be refunded the full registration fee less a \$25.⁰⁰ administration fee. No cancellation refund will be provided after 19 April.

Complete this form and return it to PHC Ethics Services by **Monday, April 19, 2010.**

By FAX: 604-806-9071

By MAIL: Ethics Services
c/o St. Paul's Hospital
1081 Burrard Street
Vancouver, BC V6Z 1Y6

By EMAIL: jmonthatawil@providencehealth.bc.ca

www.providencehealthcare.org/ethics_services/