# Conference Registration • Fill In and Return

**45th Annual Conference "Activities Bringing Joy to the World" • July 28-31 2019**

Name:______________________________________________ Phone: ___________________________

Email:_____________________________________________________________________________________

Facility:____________________________________________ District #: _________________________

Facility Address: _____________________________________ City, St., Zip: ______________________

Home Address:_______________________________________City, St., Zip: ______________________

When paying By Credit Card please include Authorization Form from the website: **www.FHCACA.com**

Member (F.H.C.A.C.A.)? ❑ Yes ❑ No Is this your first Conference? ❑ Yes ❑ No

Costs: ❑ Member Fee: $275 – 4 days ❑ One Day Registration $75

❑ Non-Member Fee: $400 – 4 days ❑ Non-Member One Day Registration $150

❑ Late Fee: $50 (if received later than July 10, 2019) Vegetarian: ❑ Yes ❑ No

Extra Banquet Tickets? ❑ Yes ❑ No $55 each/how many tickets? _____

**REFUND REQUESTS** (subject to approval) must be in writing and a 25% administrative fee will be charged. All requests for refunds must be submitted prior to July 10, 2019. No refunds will be given after July 10, 2019.

Make check payable to: **F.H.C.A.C.A.** **(F.H.C.A.C.A. DOES ACCEPT ALL CREDIT CARDS.)**

**Mary D. Spikes, PO Box 4143. Seminole, FL 33775 • www.FHCACA.com**

- Fees include registration for the entire conference, breaks, meals, and hand-out materials as stated in the program.
- Requests for auxiliary aids or services identified in the Americans with Disabilities Act (ADA) should be made five (5) working days prior to the event. Call Professional Development Chair, Nancy Hawk - Cell 1-863-214-5772.
- You are responsible for hotel reservations. Call the hotel directly.

**F.H.C.A.C.A. PHOTO RELEASE:** Please read the photo release below and check the appropriate box: ___ I give my permission. ____ I DO NOT give my permission for the Florida Health Care Activity Coordinators Association to publish my name and/or photos taken at the 2019 annual conference in Orlando FL in the association's publications, videos and/or website. I further understand it is my responsibility to make sure I am not in a group photo if I do not want my picture to appear in future publications or on the FHCACA website. Please initial _____.

Note: Implied consent is granted if one of the boxes is NOT checked. PLEASE PRINT CLEARLY:

NAME:_________________________DATE:_________SIGNATURE________________________________

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# Hotel Reservation Information

**Send directly to hotel: Hilton Daytona Beach Oceanfront**

**100 North Atlantic Ave Daytona Beach, FL 32118 • Phone 386-254-8200 • Fax 386-253-8841**

Name: __________________________________ Organization: Florida Health Care Activity Coordinators Association

Address: ____________________________________________________________________________

City, State, Zip: ____________________________ Phone: ______________________________________

Arrival Date ___________ Hour (Check-in time 3:00 p.m.) ___________ Departure Date (Check-out time 12 Noon) ___________ # of people in room/sharing with ___________

A one night deposit by check or credit card is required. Check enclosed: $__________ (Personal checks NOT accepted for payment at check-out)

Please charge to my ❑ MasterCard ❑ Visa ❑ AMEX. Deposits will be billed on receipt or reservation request.

Card Number ___________ Exp. Date ___________ CVV ___________ Name on Card / Signature ___________

**CREDIT AUTHORIZATION POLICY.** All hotel room charges must be accompanied by first night's room deposit.

**ROOM RATE:** $125.00 per night/ plus taxes. **Self Parking at $5.00 Per Day**. Please inform the hotel that you are with FHCACA when making your reservation to obtain this rate. MAKE YOUR RESERVATIONS AS SOON AS POSSIBLE. **The cut off date is June 25, 2019**. After June 25, 2019, all group requests will be subject to rate/room type availability. Each room has a blow-dryer, coffee maker, iron etc.