

Conference Registration • Fill In and Return

46th Annual Conference "Flexibility is Quality • June 24-26, 2021

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: \$150 – 3 days One Day Registration \$75

Non-Member Fee: \$250 – 3 days Non-Member One Day Registration \$150

Late Fee: \$50 (if received later than June 10, 2021) 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 June 10, 2021. No refunds will be given after June 10, 2021.

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, Chris Gerard 407-435-5897 cell.
- 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 2021 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 _____

Hotel Reservation Information

Send directly to hotel: **Rosen Plaza Hotel**

9700 International Dr Orlando FL. 407-996-9700 Fax 407-996-9111

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: \$115.00 per night/ plus taxes. **Parking fee will be waived.** 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 3, 2021.** After June 3, 2021, all group requests will be subject to rate/room type availability. Each room has a blow-dryer, coffee maker, iron etc.