



Connecticut Association Of Health Care Facilities, Inc.

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REGISTRATION and SEMINAR PAYMENT POLICY

Best Practices – Hot Topics Series – CAHCF/CCAL Member Only

February 27, 2026 and March 31, 2026

Time: 10:00 a.m. to 1:00 p.m. VIRTUAL EVENT

CEU: 3.0 per seminar

Please send this registration form, along with payment to the CAHCF offices no later than 2/22/26 ***we cannot process your registration without your payment. If you register using a purchase order number we will reserve your seat, however, full payment MUST BE REMITTED PRIOR to the event. Registrants will not be allowed to attend if any seminar fees are unpaid.***

Virtual Registration Fees:

CAHCF/CCAL Members Only: \$100 per person, per session. **Discounted rate for additional attendees: \$60 for individual sessions.**

CAHCF/CCAL Members Not In Good Standing: \$200 per person, per session.

Sessions will not be recorded.

The same person does not have to attend each session.

Cancellation Policy: Cancellations must be made in writing to CAHCF/CCAL by 4 p.m. **three business days prior** to the program date. Cancellations after this time/date and no shows will be charged the full registration fee. Cancellations can be emailed to amanning@cahcf.org, cancellations by phone will not be accepted.

Substitutions: Substitution of attendees is allowed, please notify CAHCF/CCAL in advance.

Confirmations: Confirmations will be sent via email. If you don't receive a confirmation email the day before the event, please contact Adriana Manning at amanning@cahcf.org or (860) 290-9424.

CEUs:

The CEU certificate for each session will be sent to the registered attendee provided that the session is paid and attendance is verified.

FAX YOUR FORM TO US AT 860-290-9478! Or Email to amanning@cahcf.org

Member Fee \$100 per person, per session. Discounted rate for additional attendees: \$60 for individual sessions

Members Not In Good Standing: \$200 per person, per session or \$600 for both

Facility: _____

Phone: _____ **Fax:** _____

Name	Title	Email	2/27	3 / 31
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Optional: Credit Card Information: Amount to Charge: _____

Name on Card:	Billing Address if different from facility's:
Card Number:	City, State, Zip
Expiration Date:	Security Code:
Signature:	