

Register Online:

<https://tinyurl.com/93annualmeeting>

CAHCF/CCAL

213 Court Street, Suite 202 Middletown, CT 06457

MEMBER REGISTRATION FORM

CAHCF/CCAL 93rd Annual Meeting

Thursday, July 14, 2022, The North Lawn of Mystic Seaport

Fee: \$65 per person

Kosher Meal Option:
Please see below!

COVID-19 Vaccine Requirement Policy: By registering for the CAHCF/CCAL Annual Meeting, you are attesting that you are in compliance with Connecticut’s long term care facility staff vaccination Executive Order 13B and related Department of Public Health Implementation Guidance.

Seminar Registration Policy: Please send the enclosed registration form, along with payment to CAHCF no later than July 7, 2022. We cannot process your registration without payment. **Full payment is due PRIOR to the event.** Your registration is your commitment to pay, if you do not attend you will be responsible for payment

Registrants WILL NOT BE ALLOWED TO ENTER the event if FEES ARE UNPAID, personal checks and cash will be accepted at the door.

Walk-In Registrations WILL NOT BE ACCEPTED.

Confirmations: Confirmation letters will be sent via email to email address on file for the person.

Cancellations: Cancellations must be confirmed by obtaining a “CAHCF Cancellation Number” prior to 7/7/22.

NO REFUNDS will be given after 7/7/22. Substitutions can be made, please call CAHCF to notify them of the change.

Dress Code: Casual, Neat Attire. The day will be outdoors, under a tent by the water.

Photography Policy: By registering for and/or attending a CAHCF/CCAL event, you acknowledge and agree that photographs, video, and other recordings of the event may be taken by CAHCF/CCAL or parties acting on behalf of CAHCF/CCAL, and that these photographs, video, and other recordings may be used by CAHCF/CCAL in any media now known or later invented for any purpose related to CAHCF/CCAL’s mission, including educational, promotional, and awareness related uses.

Fax registration forms to: 860-290-9478

PLEASE PRINT LEGIBLY!

Name: _____ Position: _____ Kosher Meal: ___ Yes ___ No

Name: _____ Position: _____ Kosher Meal: ___ Yes ___ No

Name: _____ Position: _____ Kosher Meal: ___ Yes ___ No

Facility: _____

Contact Person’s Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

If paying by credit card:

Scan to Register Online!



Name on Credit Card: _____	Type of Card: _____
Card Number: _____	Expiration Date: _____ Amount to Charge:\$ _____
Security Code: 3 digits for Visa and MasterCard, 4 digits for American express: _____	Billing Address if different: _____ _____