Check and Interdepartmental Fund Transfer Team Registration Form *(Please photocopy as needed)*

MAIL TO:
CHARLOTTE AHEC REGISTRAR
P.O. Box 32861, CHARLOTTE, NC 28232-2861

FAX TO: 704.512.6062
All Credit Card Payments:
REGISTER ONLINE AT:
www.charlotteahec.org

Participant Information

1

Last Name ____ First Name ____ MI ____ Last Four Digits of SSN *(required)* ____ ____ ____ ____

Degree / Certification / License ____ Employer and Department ____ Specialty ____

2

Last Name ____ First Name ____ MI ____ Last Four Digits of SSN *(required)* ____ ____ ____ ____

Degree / Certification / License ____ Employer and Department ____ Specialty ____

3

Last Name ____ First Name ____ MI ____ Last Four Digits of SSN *(required)* ____ ____ ____ ____

Degree / Certification / License ____ Employer and Department ____ Specialty ____

Work Address *(Street / P.O. Box, City, State, Zip, County)* ____

Home Phone ____ Work Phone ____ Fax ____ Email ____

Disclaimer: By providing your fax number, email address and telephone number, you have granted permission for us to contact you via the numbers and address indicated. Would you like your name removed from our mailing list? ☐ Yes ☐ No

List the program(s) that you would like to attend:

Program Title	Event #	Program Date(s)	Fee
	Total Amount Paid:		

Payment Methods: ALL CREDIT CARD PAYMENTS MUST REGISTER ONLINE AT: ***www.charlotteahec.org***

Check:

Payor Name-____

Check Number- ____ Amount- ____

Interdepartmental Transfer of Funds: (Carolinas HealthCare System Employees Only)

Department Name: ____ BU# ___ ___ ___ ___ Dept. # ___ ___ ___ ___ ___ ___

Revised: March 2017