

SOS OFFICE WORKSHOP

Registration Form

How did you hear about our workshop?

Practice Name _____

Doctor Name _____ Email _____

Street Address _____

City _____ State _____ Zip Code _____

Phone# _____ Fax# _____

# of Attendees	Attendee Name	Job Title	Tuition
1st			\$299
Email Address: _____			
2nd			\$249*
Email Address: _____			
3rd			\$249*
Email Address: _____			
4th			\$249*
Email Address: _____			

*To receive group discount, attendees must be from the same office.

Total Enclosed \$ _____

Discount Code:

PLEASE INDICATE PREFERRED WORKSHOP LOCATION:

City _____ State _____

PAYMENT OPTIONS: Check (payable to SOSHMS) Visa MasterCard 

Name on Card _____

Credit Card # _____ Exp. (mm/yy) _____ CVV # (on back of card) _____

Billing Address [must match the address on your credit card statements]: Same as above

IF DIFFERENT: Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Signature _____

Print and Fax Completed Order Form to: 425-235-8886

Or mail to: SOS Healthcare Management Solutions, LLC • 3866 Monterey Place NE • Renton, WA 98056

Questions? Call us Toll Free: 1-866-832-6767