

PERSONAL INFORMATION:

ATTENDEE 1:

ATTENDEE 2:

Name: _____	
Address: _____	
City/State/Zip: _____	
Daytime Phone: _____	
*Email: _____	

*** To receive confirmation of your registration, you must provide an email address.**

Lunch: Chicken Vegetarian

MY SELECTION OF TOPICS:

SAMPLE ^{1ST CHOICE} **1C** ^{2ND CHOICE} **1A**

ATTENDEE 1:

ATTENDEE 2:

Session 1

1ST CHOICE 2ND CHOICE

1ST CHOICE 2ND CHOICE

Session 2

1ST CHOICE 2ND CHOICE

1ST CHOICE 2ND CHOICE

Session 3

1ST CHOICE 2ND CHOICE

1ST CHOICE 2ND CHOICE

Spaces in each session will be filled in order responses are received.

Pre-registration is \$50 and must be received by Wednesday, Sept. 28.

On-site registration \$60, subject to availability.

Sorry, no refunds.

The fee for the 7th annual Women's Health Conference is \$50 per person and includes a continental breakfast, seated lunch, signature gift bag and parking.

METHOD OF PAYMENT:

Credit Card

Check Enclosed - Payable to Doctors Community Hospital

Name of Credit Card Holder: _____

Credit Card Type: Visa MasterCard Discover American Express

Credit Card Number: _____

Exp Date: _____ Security Code: _____

Amount to Charge: \$ _____ Signature: _____

Mail completed form to: Community Relations
 Doctors Community Hospital
 8118 Good Luck Road
 Lanham, MD 20706

OR fax to: 240-542-2965

For more information and/or questions,
 please call **301-552-8060**
 or visit **www.DCHweb.org**.