

CMS & TJC Standards on Informed Consent Registration Form

AUDIENCE:

CEO, COO, CNO, OR Directors,
HIM Directors, In & Outpatient Direc-
tors, TJC Coordinators, QI Directors,
Risk Managers, Patient Safety Offi-
cers, Compliance Officers

DATE:

March 18, 2010
8:00 am—8:30 am pm MST

PRICES:

MHA Members: \$165/line
Non-Members: \$210/line

REGISTER BY:

March 14, 2010

SERIES OVERVIEW

This program will discuss the current CMS hospital CoP informed consent requirements and the 2010 JC informed consent standards. The CMS requirements for CAHs will also be addressed.

Contact Person: Please fill out the contact information for the person that will be responsible for receiving and distributing dial-in information and handouts.

REGISTRATION INFORMATION

To ensure your spot at this audioconference, please fill out the information below, completely, and fax to MHA at (406)443-3894, Attn: Jennifer Wagner. **You may also register online at www.mtha.org.**

REFUNDS Fees will be refunded only if written cancellation is received by MHA by 5 pm on March 16, 2010. Fax written cancellation to MHA at (406)443-3894, Attn: Jennifer Wagner. E-mails and phone call cancellations will not be accepted.

Participant Information:

Facility Name: _____
Contact Name: _____
Email Address: _____
Facility Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

YES! We wish to participate in the audioconference. I understand we will be emailed the dial-in number, agenda, and materials prior to the conference. _____ **Number of lines** _____ **MHA Member(\$165/line)** _____ **Non Member(\$210/line)**

Payment Information *(All credit card information is required and must be complete).*

Total Payment Due: \$ _____

Visa Mastercard Discover American Express
Card number: _____ Expiration Date: _____
Cardholder Name: _____ CVS #* _____
Credit Card Complete Billing Address _____
Signature: _____

*The CVS number is the 3 digit number on the back of your card. For AMEX it is 4 digits on the front

A check, payable to MHA is being mailed to P.O. Box 5119; Helena, MT 59604-5119

Please invoice me—MHA Member Facility PO#: _____

FOR INTERNAL USE ONLY: DATE PAID: _____ REGISTRATION ENTERED (DATE): _____ BY: _____
CONFIRMATION SENT (DATE): _____ BY: _____

ACCOUNTING CODE: 08-10-07 CHECK#: _____ AMT: _____ INVOICE (DATE): _____ BY: _____