

SHM LEADERSHIP ACADEMY

REGISTRATION FORM



800-843-3360



leadership@hospitalmedicine.org



267-535-2911

Mail Registration Form and Payment to:

Society of Hospital Medicine, P.O. Box 822898, Dept. 301, Philadelphia, PA 19182-2898

Register online at shmleadershipacademy.org/register

PERSONAL INFORMATION

First Name	Last Name
Preferred Mailing Address*	
City, State/Province, Zip/Postal	
Phone	
Company/Institution	
Email (mandatory)	
Special Needs (e.g. wheelchair access, meal requirement(s), etc.)	
SHM ID# (optional)	

*Please provide the mailing address that is preferred for receiving mailed course materials.

DEMOGRAPHICS

- Medical Director Hospitalist Other (please specify): _____
- Associate/Assistant Medical Director Administrator/Manager

SPECIALTY:

Registrants will receive an email confirmation **within one week** of receipt of registration application.

*If you intend to fax or mail your registration please email leadership@hospitalmedicine.org to ensure there is space available in the preferred course.

TUITION

SHM Member

Non-Member

	SHM Member	Non-Member
Strategic Essentials	<input type="checkbox"/> \$2,095	<input type="checkbox"/> \$2,495
Influential Management	<input type="checkbox"/> \$2,095	<input type="checkbox"/> \$2,495
Mastering Teamwork	<input type="checkbox"/> \$2,095	<input type="checkbox"/> \$2,495

Not a member of SHM? Join today to receive discounted rate!

CANCELLATION POLICY

Notice of registration cancellation must be submitted in writing via mail, fax or email. Cancellations will not be accepted by telephone. The postmark, fax or email date will determine your refund using the following schedule:

- Cancellations prior to **August 27, 2018** will receive a full refund less a \$300 administrative fee.
- Cancellations on or after **August 27, 2018** are not refundable.

DISCOUNTS

5% Discount per person for groups of 3 – 5 registrants

Groups of 6 or more are eligible for a 10% discount per person. A letter of agreement between SHM and the institution is required. Please contact leadership@hospitalmedicine.org for more information.

PAYMENT

Check Enclosed
(payable to the Society of Hospital Medicine)

OR



Please remit in U.S. funds drawn on a U.S. bank.

Cardholder Name														CVV							
Credit Card Number															Expiration Date		M	M	/	Y	Y
Total Charged		\$						Cardholder's Signature													