

# Dietary Boot Camp



Please Check One:

☐ April 12-13, 2017 ☐ August 2-3, 2017

8:30 a.m. - 4:30 p.m., AHCA Training Room, Suite 175

Members \$200, Non-Members \$1,000

Lunch Included

To register, send this completed form to:

Mail: 1401 W. Capitol Ave., Suite 180, Little Rock, AR 72201 / Fax: 501-374-1077 / Email: lkindy@arhealthcare.com

The information contained herein, together with all attached documents, will be regarded as property of AHCA.

First Name \_\_\_\_\_ M. \_\_\_\_\_ Last Name \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address (to receive confirmation, class information, and notifications) \_\_\_\_\_

Employer \_\_\_\_\_ Current Title \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Attendee's Signature \_\_\_\_\_ Date \_\_\_\_\_

PAYMENT TOTAL: \$ \_\_\_\_\_

☐ Check #: \_\_\_\_\_ ☐ Visa ☐ Master Card ☐ American Express

Name on Card: \_\_\_\_\_ Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ V-Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Credit Card Receipt to: \_\_\_\_\_

**SPACE IS LIMITED. ADVANCED REGISTRATION IS REQUIRED.**

**PAYMENT DUE BY FIRST DAY OF CLASS.**

**CONFIRMATION WILL BE SENT.**

For more information, please contact Lori Kindy, Director of Education,  
501-374-4422, lkindy@arhealthcare.com

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