

# Individual Registration Worksheet – Educator Wellness Conferences 2008

(Reproduce and distribute to each participating member) -

FAX to (817) 496-5800 or Submit ONLINE REGISTRATION Below

REP ID#: TWHI0716



## Individual Contact Information (Please print legibly or type if registering by fax or mail)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_

Email (MANDATORY – must be accessible all year) \_\_\_\_\_

District Name \_\_\_\_\_ School Name \_\_\_\_\_

Home Phone \_\_\_\_\_ School Phone \_\_\_\_\_

Position within School District \_\_\_\_\_

Educator Wellness Site Team Role:  Site Coordinator  Site Administrator

Counselor  Teacher  Other (specify) \_\_\_\_\_

Check here if you are a Regional Director / Coordinator or District Director



## Conference and Session Selection

Please check which conference you will attend:

Grapevine, Texas  
October 5-6, 2008

Session Selection #'s (Session titles listed below - choose at least 6): \_\_\_\_\_

Detailed session descriptions are available online at [educatorwellhealth.com](http://educatorwellhealth.com).



## Payment Method

**Early Bird**  
Postmarked or received by  
**September 8, 2008**

**Regular**  
**AFTER September 8, 2008** or  
Postmarked or received by  
September 22, 2008

**Late**  
Postmarked or  
received **AFTER**  
September 23, 2008

**Two-day conference**  \$ 385

\$ 435

\$ 485

(\*Late fees apply starting September 23, 2008)

If you are sending payment by fax or mail, please complete the fields below to indicate how payment will be made. Registration and session selection ARE NOT guaranteed until payment is received by Educator Well-Health. Please make checks and purchase orders payable to Educator Well-Health, Inc.

Purchase Order # \_\_\_\_\_  Check # \_\_\_\_\_

Visa  Mastercard # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month / year

Print Name on Card \_\_\_\_\_ Phone Number \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature authorizes Educator Well-Health to charge the above credit card for Educator Wellness Conference registration fees as indicated on this form.

For Educator Well-Health, Inc. use only: Received Date \_\_\_\_\_ Initials \_\_\_\_\_ Enter Date \_\_\_\_\_ Initials \_\_\_\_\_