

PRSA Training Order Form

Program: The Affordable Health Care Act Product: TEL5212/REPLAY
MyPRSA ID: _____
First Name: _____ Last Name: _____
Title: _____ Organization: _____
Address: _____
City: _____ State/Province: _____
Postal Code: _____ Country: _____
Email: _____ Phone: _____
Fax: _____

Health Academy Members: \$0 PRSA Members: \$0 Nonmembers: \$200

Coupon/Promotion Code: _____

Payment Method

Enclosed check, payable to PRSA

Credit Card: American Express Master Card Visa

Card Number: _____

Expiration Date: ____ / ____

Cardholder Name: _____

Signature: _____

If paying by check, mail this form with your payment to: PRSA Registration, 411 Lafayette Street, Suite 201, New York, NY 10003

If paying by credit card, fax this form to: (212) 460-5460

No event registrations will be processed without proper payment.

Cancellation Policy

Cancellations must be in writing and sent by mail to PRSA Registration, 411 Lafayette Street, Suite 201, New York, NY 10003, or faxed to (212) 460-5460. Cancellations are subject to a \$25 cancellation fee. There are no refunds once you receive your registration confirmation.