



## INFECTION CONTROL SEMINAR REGISTRATION FORM

Please complete the following information for scheduling an infection control seminar. **(Please type or print legibly.)**

Name of establishment: \_\_\_\_\_

Address of establishment: \_\_\_\_\_

\_\_\_\_\_

Should you wish to have the seminar conducted at the establishment please have a room or location within the establishment free of distraction and interruption.

If the seminar will be conducted at a location other than the establishment, please list the name of the establishment and the full address of that location:

Name of establishment: \_\_\_\_\_

Address of establishment: \_\_\_\_\_

\_\_\_\_\_

Please list two dates of preference for the seminar: \_\_\_\_\_  
(Month) (Day)

\_\_\_\_\_  
(Month) (Day)

Please list preference of time: \_\_\_\_\_

Number of expected attendees: \_\_\_\_\_

Name of contact person: \_\_\_\_\_

Phone number of contact person: \_\_\_\_\_

**Do you have technology in the room/location where the seminar will be conducted to view?**

**DVD Presentation:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Power Point Presentation:** Yes \_\_\_\_\_ No \_\_\_\_\_

Submit the completed form to the above address. Should you need additional information regarding the infection control seminar or have scheduling questions, please do not hesitate to contact this office.