



# CERTIFICATION PROGRAM MAIL IN REGISTRATION FORM

## REGISTRATION INFORMATION

Please print this form and complete all sections. The information you provide will be used for all program correspondence and name badges.

Mail, with payment, to

Hansten Healthcare, PLLC  
101 Merridith Street  
Port Ludlow, WA 98365

For more information, contact Ruth Hansten via:

Phone at 360-437-8060 or  
Email at [ruth@hansten.com](mailto:ruth@hansten.com)

## PLEASE NOTE

- All team members must register together to be eligible for the team rate discount.
- Refunds for cancellations, less a \$100 processing fee, will be made if Hansten Healthcare is notified in writing (email or fax) no less than 10 days before the program start date. For cancellations less than 10 days before the program start date, fees may be applied to future programs (less a \$100 processing fee.)
- Please complete all sections of the registration form. The information you provide will be used for all program correspondence & name badges.
- All registrations must include the appropriate fees. Mail in registration forms must be accompanied by a check. Credit card payments must be made online at [www.rrohc.com](http://www.rrohc.com).

## PROGRAM REGISTRATION FEES

### Level 1 RROHC™ Specialist Certification Program

Individual participant rate..... \$675/each

**Number of Team Members Registering** \_\_\_\_\_

### Level 2 RROHC™ Facilitator 3-Day Certification Program

Special introductory fee for Inaugural 3-day session plus 6-months of ongoing education (100 contact hours)

Individual participant rate .....\$2,850/each

Team rate (4 or more from 1 facility).....\$2,600/each

**(Please note that rates do not include transportation, meals or lodging at the Inn at Port Ludlow.)**

### Foundations in Relationship & Results Oriented Health Care™ 1-Day On Site Seminar

Contact Ruth Hansten via email at [ruth@hansten.com](mailto:ruth@hansten.com) or Kathy Watkins at [kathy.watkins@hansten.com](mailto:kathy.watkins@hansten.com) to schedule a seminar at your facility or to obtain more information.

## CONTACT INFORMATION

Name \_\_\_\_\_

Credentials \_\_\_\_\_

Position/Title \_\_\_\_\_

Organization \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Email \_\_\_\_\_

I need special services in accordance with the American with Disabilities Act

Additional team members (include name, credentials, position/title; use a separate piece of paper if you need more room)

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**Total Amount Enclosed** \_\_\_\_\_