eClinicalWorks

March 26 & 27, 2010 Northeast Regional Users' Group Meeting

First Name: ____ Last Name: ____

Degree Initials: ___________________ Organization: ____

Specialty: ___________________________ Title: ________________________________Number of Providers in Practice: __________________

Address: ____

City: ________________________________ State: _______________________ Zip: ____________Phone: _______________________________

Cell Phone: _______________________________Email: ____

Special Considerations: (dietary restrictions, accessibility needs, etc.): ____

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Which of the following best describes the environment where you spend most of your day? Check all that apply.

- ☐ Hospital (<300 beds)
- ☐ Medium group practice/clinic less than 100
- ☐ Health Center
- ☐ Consulting Firm
- ☐ Other ______________________________
- ☐ Hospital (over/equal 300 beds)
- ☐ Solo or small group practice/clinic
- ☐ RHIO, Regional Health Information Org.
- ☐ IS/IT Vendor
- ☐ Large group practice/clinic 100+
- ☐ Specialty Office
- ☐ IPA, Independent Physicians Organization
- ☐ Payer

Which of the following best describes your role within your organization? Check all that apply.

- ☐ Billing Manager
- ☐ Billing Staff
- ☐ Business Analyst
- ☐ CIO
- ☐ CTO
- ☐ Front Office Staff
- ☐ IT Network Manager
- ☐ Medical Assistant
- ☐ Network Manager
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Office Manager
- ☐ Physician
- ☐ Physician Assistant
- ☐ Practice Administrator
- ☐ President, CEO, Exec. VP
- ☐ Quality Manager
- ☐ Resident
- ☐ Vendor/Exhibitor
- ☐ VP of Finance
- ☐ Other: _______________

Registration Fee:

	Thru Feb 19th	**After Feb 19th**
Full Conference Registration:	$75.00	$100.00
I have a special discount code:	__________	
Payment Total:	__________	

☐ A check for $ ____________ is enclosed. Please make check payable to **eClinicalWorks.**

☐ Please charge credit card: ☐ Visa ☐ MasterCard ☐ American Express

Credit Card Number: ____ Exp. Date: ___________________CVV Code: __________________

Name as it appears on Card: ____

Billing Address: ____

City: ____ State: ______________________________ Zip: _________________________________

Authorized Signature: ____

Submit this form to:

2010 Northeast Regional Users' Group Meeting
eClinicalWorks, LLC – Attn Lynne Haglund
112 Turnpike Road, Suite 200
Westborough, MA 01581
Fax (508) 836-4466

Registration Cancellation Policy:

Cancellations received by February 26, 2010 will be refunded, less a $50 cancellation fee. Refunds cannot be given after February 26, 2010. Notice of cancellation must be received in writing and submitted to address above or emailed to lynneh@eclinicalworks.com