



Team Registration Form

MAIL TO:
CHARLOTTE AHEC REGISTRAR
 P.O. Box 32861, CHARLOTTE, NC 28232
 FAX TO: 704.512.6062

All participants must have MyAHEC accounts before utilizing this form
To create a MyAHEC account go to <https://www.charlotteahec.org/create-account>

1 Last Name _____ First Name _____ MI _____ Credentials _____
 MyAHEC login(email) _____

2 Last Name _____ First Name _____ MI _____ Credentials _____
 MyAHEC login(email) _____

3 Last Name _____ First Name _____ MI _____ Credentials _____
 MyAHEC login(email) _____

Work Address (Street /P.O. Box, City, State, Zip, County) _____

Work Phone _____ Supervisors email _____

List the program(s) that you would like to attend:			
Program Title	Event #	Program Date(s)	Fee
Total Amount Paid:			

Payment Methods: **ALL CREDIT CARD PAYMENTS MUST REGISTER ONLINE AT: www.charlotteahec.org**

Check:
 Payor Name- _____
 Check Number- _____ Amount- _____

Interdepartmental Transfer of Funds: (Carolinas HealthCare System Employees Only)

Department Name: _____ BU# _____ Dept. # _____

Disclaimer: By providing your fax number, email address and telephone number, you have granted permission for us to contact you via the numbers and address indicated. Would you like your name removed from our mailing list? Yes No