



**Check and Interdepartmental Fund Transfer Team
Registration Form** *(Please photocopy as needed)*

MAIL TO:
CHARLOTTE AHEC REGISTRAR
P.O. Box 32861, CHARLOTTE, NC 28232-2861

FAXTO: 704.512.6062
All Credit Card Payments:
REGISTER ONLINE AT:
www.charlotteahec.org

1 Last Name _____ First Name _____ MI _____ Credentials _____
Last Four of SSN _____ Email _____

2 Last Name _____ First Name _____ MI _____ Credentials _____
Last Four of SSN _____ Email _____

3 Last Name _____ First Name _____ MI _____ Credentials _____
Last Four of SSN _____ Email _____

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

Work Phone _____ Supervisors email _____

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

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. # _____