Event Registration Form

3rd Annual NFSMPHX September 24, 2021

Please return this form by mail or email to:

NFSMPHX 4350 E St. John Rd Phoenix, Az 85032

For any queries or help completing this form, please contact 623-201-8545 or nfsmphx@gmail.com

ABOUT YOU: (please complete one per staff member) 1

Title: _____ **First Name:** _____ **Last Name:** _____

Business Address: _____

Email: _____@_____ **Direct Contact #:** (_____) - _____ - _____

Company Name: (if applicable) _____

Company Website: (if applicable) _____._____

ABOUT YOU: (please complete one per staff member) 2

Title: _____ **First Name:** _____ **Last Name:** _____

Business Address: _____

Email: _____@_____ **Direct Contact #:** (_____) - _____ - _____

Company Name: (if applicable) _____

Company Website: (if applicable) _____._____

ABOUT YOU: (please complete one per staff member) 3

Title: _____ **First Name:** _____ **Last Name:** _____

Business Address: _____

Email: _____@_____ **Direct Contact #:** (_____) - _____ - _____

Company Name: (if applicable) _____

Company Website: (if applicable) _____._____

ABOUT YOU: (please complete one per staff member) 4

Title: _____ **First Name:** _____ **Last Name:** _____

Business Address: _____

Email: _____@_____ **Direct Contact #:** (_____) - _____ - _____

Company Name: (if applicable) _____

Company Website: (if applicable) _____._____

TELL US MORE ABOUT YOUR COMPANY

What type of provider are you? Check all that apply

- ☐ *Association for Seniors*
- ☐ *Caregiver Staffing Agency*
- ☐ *CPA*
- ☐ *Dentists*
- ☐ *Home Health*
- ☐ *Hospice*
- ☐ *Medical Supplies*
- ☐ *Occupational Therapy*
- ☐ *Older Adult Volunteer Organizations for Seniors*
- ☐ *Palliative Care*
- ☐ *ALTCS Assistance*
- ☐ *Physical Therapist*
- ☐ *Public Fiduciary*
- ☐ *Realtor*
- ☐ *Referral Agency*
- ☐ *Rehab Center*
- ☐ *Social Workers*
- ☐ *Speech Therapists*
- ☐ *Transport*
- ☐ *VA Assistance*
- ☐ *Vision Center*

Other: _____

Mobile Services:

- ☐ *Beauticians,*
- ☐ *Behavioral Assistance*
- ☐ *Density*
- ☐ *Doctor*
- ☐ *Emergency Services*
- ☐ *Entertainment*
- ☐ *Health Screenings*
- ☐ *Labs & X-rays*
- ☐ *Notary*
- ☐ *Optometry*
- ☐ *Pain Management*
- ☐ *Podiatry*

Other: _____

Sponsor Fee

☐ **Title Sponsor Package $5,000 (1 Available)** ☐ **Platinum Package $3000 (3 Available)**
☐ **Gold Package $2000 (5 Available)** ☐ **Basic Package $750 (10 Available)**

Declaration: I confirm that I have read and agree to terms and conditions set out by NFSMPHX

Signature: **Date:**

Name:

PAYMENT

☐ **Check - please make check payable to INtouch Assisted Living**

☐ **Credit/Debit – please complete all details below, please do not email this form with details completed**

Cardholders Name: ☐ **Visa** ☐ **MC** ☐ **AMEX** ☐ **Discover**

Cardholders Address: (the address the card is registered to)

Zip code:

Card #: **Exp Date:** **CVC Code:**

Mail Checks To: 4350 E St John Rd Phoenix, AZ 85032