HIV/AIDS Nursing Review Examination Group Registration Application Form

Please complete (type or print) the following form for EVERY ACRN *HIV/AIDS Nursing Review Examination* candidate that will fall under the group registration discount. Please remember that a minimum of 8 people must sign up to take the *HIV/AIDS Nursing Review Examination* to be eligible for the group rate. Once payment has been made and verified, an email will be sent to each registrant with a username and password.

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

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First Name _____ Last Name _____

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City _____ _____ State _____ Zip _____

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First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

First Name _____ Last Name _____

Address_____

City _____ _____ State _____ Zip _____

Email _____ Phone (___)_____

HIV/AIDS Nursing Review Examination Group Registration Payment

Contact Person _____

Address _____

City, State, Zip _____

Daytime Phone _____Evening Phone _____

Email _____

Number of Registrants _____ Minimum of 8 registrants required to receive discount

x $35.00

Total Due $_____

Method of Payment

☐ Check ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

_____

Credit Card Number _____CVV#_____Exp. Date _____

Name on Card (Please print)_____

Billing Address _____

Signature of Cardholder _____Date _____

Registration fee covers a one time use of the *HIV/AIDS Nursing Review Examination* for each member. A username, password and instructions will be emailed to each individual registered. Please contact HANCB at (800) 260-6780 if you have any questions.