

**COVID Relief Bill - Another Round
of PPP and so Much More!**

REGISTRANT INFORMATION

Name: _____ NAB Identifier: _____

Title: _____

Facility Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____ Fax: _____

PAYMENT INFORMATION
MEMBERS: \$75 | NON-MEMBERS: \$100

PLEASE SEND YOUR REGISTRATION TO ERIN ARMSTRONG VIA

EMAIL: earmstrong@nyshfa-nyscal.org | **FAX:** 518.426.4051

MAIL TO: Foundation for Quality Care • 33 Elk Street • Suite 300 • Albany • NY • 12207

Check Visa American Express Mastercard Discover

Credit Card Number: _____ Exp. Date _____

Name on the Card: _____

Cardholder Signature* _____

Total Amount Due: \$ _____

* I authorize NYSHFA/NYSCAL/FOC to use the above Discover, MasterCard, VISA, or AMEX to charge applicable registration fees. I also understand that registration fees of those who cancel the day of the program or fail to attend are forfeited. PLEASE NOTE: Payment Will Show on Your Credit Card Statement as NYS Health Facilities Association.

