

CAHF Region V Wine Tasting Registration:

Name: _____

Guest Name: _____

Guest Name: _____

Guest Name: _____

Guest Name: _____

Facility/Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Chapter you represent: ___OC___SD___IE Number of Tickets requested: _____

Vegetarian: ___Y___N

Payment

___ Check: # _____ (please make checks out to OCCAHF)

___ Credit Card (circle): VISA MC AMEX

I, _____ AUTHORIZE SAN DIEGO HEALTH CARE ASSOCIATION
(please print)
TO PROCESS THE TOTAL AMOUNT OF \$ _____

Name on Card: _____

Number: _____ CVC: _____

Address for Card (if different than above): _____

I acknowledge purchasing ___REGISTRATION(s) for the Region V Wine Tasting Event

Signature _____ Date _____

Please Note: Credit card information will not be kept on file. This document will be shredded after processing

Fax or Email Registration to:

Tiffany Karlin

Fax: 562-624-9818 Email: tkarlin@accure.biz