28th Annual Trauma Symposium - May 11-13, 2026

AtlantiCare Employee – Registration Form

To register, please complete this form and mail or fax (609-441-8178) with full payment to:
ARMC Trauma Center, 1925 Pacific Avenue, 8th Floor, Atlantic City, NJ 08401

Please make checks payable to: ARMC Trauma Symposium

☐ Physician ☐ PA ☐ Nurse ☐ Respiratory ☐ ALS ☒ AtlantiCare Employee

Name: Credentials:

Address: Affiliation:

City/State/Zip: Work Phone: Cell Phone:

Email Address (REQUIRED):

Early Registration By May 4	Physician	Nursing/PA/ ALS/ Respiratory /Other Allied*
May 11-13, 2026 (Full Conference – 16 credits)	$395	$279
May 11 or May 13, 2026 (Half Day – May 11 4 credits or May 13 – 4 credits)	$180	$110
May 12, 2026 (Full Day – 8 credits)	$240	$175

- A $50.00 late fee will be charged for registrations received after May 4, 2026.
- Tuition fees include food provided at designated times.
- Four-week cancellation notice is required for a refund.
- Course registration fee is refundable minus a $75 administrative fee.
- On-site registration will be accepted on a space-available basis.

*Allied Healthcare Provider – Respiratory therapists, physical therapists and EMS

Please register me for the following:

☐ May 11-13, 2026 (Full Conference) $

☐ May 11 or ☐ May 13, 2026 (Half Day) $

☐ May 12, 2026 (Full Day) $

☐ Late Fee after May 4, 2026 ($50.00) $ 50.00

$ (Total)

Payment Information:

Payroll Deduction:

*I authorize AtlantiCare Regional Medical Center to deduct the registration fee for the **28th Annual Trauma Symposium 2026** from my pay as follows:*

☐ **ONE** ☐ **TWO** consecutive pays.

(Please check preference, if no preference is checked; one consecutive pay will be used)

Employee Name: Clock number:

Total Deduction:

Signature: _____

Credit Card:

☐ Visa ☐ MC ☐ AmEx ☐ Discover

Credit Card Number:

CVC Code:

Expiration Date: /

Cardholder's Name:

Signature: _____

Billing Address zip code:_____