Leading Organizations to Health: Transformative Leadership for Healthcare

Name: ______________________________ Day Phone: ________________________

Address: ____________________________ Evening phone: _____________________

____________________________ E-mail: ___________________________

Organization: _________________________ Position: __________________________

- ☐ I'd like more information about this program. Please contact me.
- ☐ Please register me. I have reviewed the Program Fee and Cancellation Policy sections of the brochure and commit to attending all four residential sessions. My deposit of $2000 is enclosed. (Please make checks payable to Relationship Centered Health Care.)

Please describe your current administrative work:

Please tell us about what draws you to this course and what outcomes you hope for. (Feel free to use additional sheets if necessary.)

Please send this application and a check for your deposit (payable to Relationship Centered Health Care) to:
Relationship Centered Health Care, 42 Audubon St, Rochester, NY 14610. Thank you!