Tuberculosis Surveillance & Testing Certification Registration Form

Form for initial and recertification process

PLEASE TYPE OR WRITE LEGIABLY. COMPLETE ALL SECTIONS.

NAME: __________________________________ **SOCIAL SECURITY NUMBER**: _________________________

TELEPHONE: ___________________________ **FAX:** ____________________________

EMAIL ADDRESS (REQUIRED): ____

MAILING ADDRESS: ____

Street or P. O. Box **City** **State** **Zip Code** **County**

TITLE: ☐ RN ☐ LPN ☐ RPH ☐ Other (*please specify, NO ABBREVIATIONS*) ________________________________

PLACE OF EMPLOYMENT& ADDRESS: ____

EMPLOYER'S CONTACT NUMBER or EMAIL: ____

Workshop Date and Location:

Workshop Time 8:15am-4:00pm:

1st Workshop Date and Location Requested:

____

2nd Workshop Date and Location Requested:

____

-In the event your first choice is unavailable your registration is moved to the 2nd choice AUTOMATICALLY-

Registration Fee: $50.00 **Discounted Rate:** $40.00 *(ONLY if* **form & fee received** *14 days prior to the requested workshop)*

PAYMENT: PERSONAL CHECKS NOT ACCEPTED. CREDIT/DEBIT CARDS ACCEPTED ONLINE, visit
https://www.ms.gov/msdh/tb_certification

I am mailing a ☐ Company Check ☐ Certified Check ☐ Money Order ☐ Cashier's Check

REGISTRATION AGREEMENT: I have completed the registration form and included an e-mail address as required. I acknowledge that registration is not final until **BOTH** the completed registration form and payment is received. I understand the registration fee is **not refundable,** unless the workshop is cancelled. If it becomes necessary to change the registration, I understand that I must provide **written notification at least 14 days prior to the scheduled workshop** to **transfer** registration to another workshop or to another person without additional charge. Transfer to another person may be requested in writing less than 14 days prior to the workshop with a $15.00 transfer fee. The transfer will not be completed until a **$15.00 transfer fee** is received. Failure to attend the scheduled workshop or transfer the fee in advance forfeits the registration fee. No transfers/substitutions are accepted after the workshop begins. *Registration confirmation or workshop cancellation will be sent by email 14 days before scheduled workshop.*

Date: _____________ Signature: ____

Send registration form and fee to:
MSDH Office of Tuberculosis and Refugee Health
P. O. Box 1700
Jackson, MS 39215-1700
Phone: (601) 576-7705 Fax: (601) 576-7520
www.healthyms.com/tb

NO WALK-INS QT'NCVG'CTTKXCNU'CTG PERMITTED.

All workshops are contingent upon the minimum participant requirement being met. Workshops will not meet if fewer than 25 participants are registered 14 days in advance. "Registration" means that the participant has submitted a complete registration form and acceptable form of payment. *Limited spaces are available at some sites.*

FOR OFFICE USE ONLY

Amount: __________ Date Received: _________

Method of Payment: ______________ Payment Number: _________________

EFFECTIVE 7/8/2014