

AORN's Periop 101: A Core Curriculum™

2014 INVOICE / ORDER FORM FOR ADDITIONAL SEATS IN SAME TERM

Use This Form If You Bought Periop 101 New or Last Renewed in 2014

**For OR Nurses, OB RN Circulators, Ambulatory Surgery Center Nurses,
PAs/Residents/Medical Students/Interns/Advanced Practice Nurses**

<i>Information About Facility</i>	<i>Information About Course Administrator</i>
Name of <u>Facility</u> on Your Order Form/Agreement: Street Address: City/State/Zip:	Name: Credentials (BSN, RN, CNOR, etc.): Title: Email Address: Telephone: (If same as Facility, leave blank): Facility Name: Address: City/State/Zip: Fax:

Please Note: All seats must be used (started) before your facility's 2-year expiration date, or they are lost.)

Student Seats by Type – Please fill in **# OF STUDENT SEATS BY TYPE:** *OR* _____ *OB* _____ *ASC* _____
For official multiple sites, which sites get how many seats and which type of seats? _____

_____ (# seats) x \$860 each -- Buy 1-10 OR/OB/ASC student seats at one time	\$ _____
_____ (# seats) x \$570 each -- Buy 11-29 OR/OB/ASC student seats at one time	\$ _____
_____ (# seats) x \$465 each -- Buy 30+ OR/OB/ASC student seats at one time	\$ _____
_____ (# seats) x \$185 each – Buy PA/Resident/Med Student/APN seats	\$ _____
_____ (# seats) x \$350 each – Buy extra Administrator seats if your free ones are used up	\$ _____
_____ (# seats) x \$89 each – Buy extra Preceptor Seats if you have used up your free ones	\$ _____
Subtract PEP Facility Discount off above student seat fees, if applicable: \$ _____	- \$ _____
_____ (# seats) x Final Exam 3 rd Attempts (\$125 each)— Student Name: _____	+ \$ _____
_____ One-Month Student Extension (\$100 per mo.)-- Student Name(s): _____	+ \$ _____
TOTAL AMOUNT	\$ _____

Signature of Facility's Duly Authorized Representative

Signature: _____ Date: _____
 Printed Name: _____ Title: _____
 Facility Name: _____

Payment Terms

All Fees are due and payable upon signing and submission of this Periop 101 Additional Seat Order Form. Purchase orders are not considered payment, and this form serves as your invoice. **The order must be paid in full** with a check or credit card payment before new seats are activated. [**You no longer need to send AORN student rosters.**]

All Fees are nonrefundable, and all seats are nontransferable.

<i>To Place Your Order</i>
<ul style="list-style-type: none"> • To place your order, please provide the information requested on pages 1-2 and return one signed copy of this Periop 101 Extra Seat Invoice/Order Form together with payment of the applicable Fees to: <div style="text-align: center; padding: 5px 0 0 0;"> AORN, Inc., Attn: Customer Service, 2170 S. Parker Road, #400, Denver, CO 80231 Or fax to (800) 847-0045 or (303) 750-3212, or email periop101@aorn.org </div> <p>Upon receipt of <i>BOTH</i> actual payment and the signed order form, AORN staff will add the additional seat accessibility for the facility typically within 3-5 business days and will email the Administrator that it has been done, so make sure you order your seats enough time in advance of your class start date.</p>
<i>All Services Provided Subject to Terms and Conditions of Periop 101 Two-Year Agreement</i>
<p>The Services described in this Invoice/Order Form are provided to you subject to the terms and conditions of the Periop 101 Two-Year Agreement between AORN and your facility. This Invoice/Order Form, any other Seat Invoice/Order Forms, and the Periop 101 Two-Year 101 Agreement together form an integrated and complete agreement.</p>
<i>Payment</i>
<p>Check #: _____</p> <p>Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover</p> <p>Credit Card #: _____ Exp. Date: _____</p> <p>Name on Card: _____</p> <p>Signature _____ Date _____</p>

Provide the following information about each additional Periop 101 Administrator(s) you are adding. Attach as many sheets as necessary.

<i>Health System Name (if any):</i> _____	
<i>Name of Facility:</i>	
<i>Facility Address:</i>	
<i>City/State/Zip:</i>	
<i>Information About New Course Administrator</i>	<i>Information About New Course Administrator</i>
Name:	Name:
Credentials (eg, BSN, RN, CNOR):	Credentials (eg, BSN, RN, CNOR):
Title:	Title:
Facility:	Facility:
Facility Address:	Facility Address:
City/State/Zip:	City/State/Zip:
Telephone:	Telephone:
Fax:	Fax:
E-Mail Address:	E-Mail Address: