# AORN's Periop 101: A Core Curriculum™

## ADDITIONAL SEAT INVOICE / ORDER FORM

## For Those Who Bought Periop 101 New or Renewed Most Recently *On or After* July 1, 2011 and *Before* January 1, 2013

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

| *Information About Facility* | *Information About Course Administrator* |
|---|---|
| **Name of Facility on Your Periop 101 Agreement:**<br><br>**Street Address:**<br><br>**City/State/Zip:** | **Name:**<br>**Credentials (BSN, RN, CNOR, etc.):**<br>**Title:**<br>**Email Address:**<br>**Telephone:**<br>**(If same as Facility, leave blank):**<br>**Facility Name:**<br>**Address:**<br>**City/State/Zip:**<br>**Fax:** |

### *Additional Periop 101 Seat Fee*

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

**Subtotals for Student Seat Registration Fees** ***(fees are the same for OR, OB, and ASC seats)***

_____ (# seats) x $795 each -- Buy 1-10 OR/OB/ASC Student seats at one time = $_____
_____ (# seats) x $495 each -- Buy 11-24 OR/OB/ASC Student seats at one time $_____
_____ (# seats) x $395 each -- Buy 25-49 OR/OB/ASC Student seats at one time = $_____
_____ (# seats) x $295 each -- Buy 50+ OR/OB/ASC Student seats at one time = $_____
_____ (# seats) x $185 each – Buy PA/Resident/Med Student/Intern/APN Student Seats $_____
_____ Additional Course Administrator Seats **($350 each)** **$**_____
_____ Final Exam 3rd Attempt **($125 each)—Student Name:**_____ **$**_____
_____ Additional Preceptor Seats if you have used up your free ones **($89 each)** **$**_____
**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 Supplemental 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 the new seats are activated. *When you are ready to start your students, be sure to submit your completed Periop 101 Online Student Registration Roster for:*

(1) the regular Periop 101 OR Course or
(2) the Periop 101 OB, ASC, or PA Course so students can be assigned the correct Learning Plan.

- **All Fees are nonrefundable**.

## *To Place Your Order*

- To place your order, please provide the information requested on pages 1-2 and return one SIGNED copy of this Periop 101 Additional Seat Invoice/Order Form together with payment of the applicable Fees to:

AORN, Inc., Attn: Customer Service, 2170 S. Parker Road, Denver, CO 80231; fax (800) 847-0045

Upon receipt of ***BOTH*** actual payment and the signed order form, AORN staff will add the additional seat accessibility for the facility typically within 53 business days and will email the Administrator that it has been done.

## *All Services Provided Subject to Terms and Conditions of Periop 101 Two-Year Agreement*

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 Additional Seat Invoice/Order Forms, and the Periop 101 Two-Year 101 Agreement together form an integrated and complete agreement..

## *Payment*

Check #:_____

Credit Card Type: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Credit Card #:_____ Exp. Date:_____

Name on Card:_____

Signature _____ Date_____

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

## *Health System Name (if any):_____*

***Name of Facility:***

***Facility Address:***

***City/State/Zip:***

| ***Information About New Course Administrator*** | ***Information About New Course Administrator*** |
|---|---|
| Name: | Name: |
| Credentials (eg, RN, BSN, CNOR): | Credentials (eg, RN, BSN, 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: |