Prep for CNOR Live
Facility Order Form

FACILITY INFORMATION

Facility Name: _____

Business Address 1: _____

Business Address 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

Phone: _____ Health Care System: _____

KEY CONTACT INFORMATION

First Name: _____ Last Name: _____

Credentials: _____ Title: _____

Business Address 1: _____

Business Address 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

Business Phone: _____ Business Email: _____

COURSE DESCRIPTION

This program includes two online assessments, a two day event, study plan, and a USB of the most current *AORN Guidelines for Perioperative Practice*. Registrants must complete the assessments, attend the two day event, and complete the evaluation to receive 17.4 contact hours.

ORDER DETAILS

No. of Registrations	Price Per Attendee
1-10	$155/attendee
11-15	$140/attendee (10% savings)
16+	$130/attendee (15% savings)

No. of Registrations: _____

Total Amount Due: $ _____

Prep for CNOR Live Event Location and Date: _____

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PAYMENT INFORMATION

METHODS OF PAYMENT

☐ **Option 1**

Pay by Phone - Email your completed form to ***orders@aorn.org*** and call Customer Service at 1-800-755-2676 to pay by credit card. **DO NOT** complete page 5.

☐ **Option 2**

Pay by Fax - Complete the credit card payment form on page 5 and fax the complete form to 1-844-241-4050.

☐ **Option 3**

Pay by Mail - Send check or complete the credit card payment form on page 5 and mail complete form to 2170 South Parker Road, Suite 400, Attn: Orders.

ORDER PROCESS

1. Complete order form and submit with payment to AORN (a purchase order is not considered payment).
2. Order will be processed and agreement activated after AORN receives both completed order form and payment.
3. Administrator(s)/contact will receive the registration email.

By signing or typing my name below, I agree to the ***AORN Terms and Conditions*** for this purchase and any future purchases. If the product purchased is for use by my facility, I am authorized by my facility to bind my facility to the terms of this agreement.

Type or sign here: _____

Date: _____

MAIL OR FAX ORDER FORM:

Attn: Orders
2170 S Parker Rd, Suite 300
Denver, CO 80231-5711
Secure Fax: 1-844-241-4050

QUESTIONS?

Contact Experience Services
US Phone: 1-800-755-2676
International Phone: 1-303-755-6300

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PLEASE DO NOT EMAIL THIS SECTION BELOW CONTAINING CREDIT CARD DATA.
Email sent with credit card numbers are not secure and will be automatically blocked.
Only complete this section if you are sending via secure fax (Option 2) or by mail (Option 3).

Credit Card Type:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number:_____ Expiration Date: _____ CVV:_____

Credit Card Holder Name:_____

Signature:_____

Purchasing Agent Name (if different from credit card holder):_____ Phone:_____

Purchasing Agent Email Address:_____

Total Amount Paid $:_____

MAIL OR FAX ORDER FORM:

Attn: Orders
2170 S Parker Rd, Suite 300
Denver, CO 80231-5711
Secure Fax: 1-844-241-4050

QUESTIONS?

Contact Experience Services
US Phone: 1-800-755-2676
International Phone: 1-303-755-6300

FOR OFFICE USE ONLY
Version: 01079 1217
Facility Name:
Account #: