



**DNA Phototherapy Workshop
Request Form**

Name: _____

Institution: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Email: _____

Approximate Date(s) for Workshop: _____

(Note: Actual date to be determined pending speaker's availability)

**Name of Person Who Will
Sign the Letter of Agreement:** _____

Cost: \$2,950 for up to 6 attendees, and \$300 for each additional attendee.
Once the number of attendees is confirmed, an invoice will be sent to you.
Payment must be received no later than 2 weeks prior to activity.

Number of Attendees: _____
(If this is not determined yet, the number of attendees will need to be determined in advance to allow time for DNA to produce an invoice and for the requester to submit payment. Payment must be received 2 weeks prior to activity.)

Full Names and Designations (i.e. NP, RN, LPN, etc.) of Attendees:

Additional Names may be added on a separate sheet of paper.

Please send this information to Ms. Julianna King via email at jking@ahint.com or via fax to 856-439-0525. Thank you