

Hospital/Facility _____
Address _____
City / Zip Code _____
Phone _____
Contact Person _____
E-mail* _____
*Required as CEU Certificates will be emailed

AzSRC Continuing Education Annual Invoice

1. _____ applications 1-4	\$50 (per application)
2. _____ applications 5-10	\$175
3. _____ applications 11-15	\$225
4. _____ applications 16-20	\$275
5. _____ applications 21-25	\$325
6. _____ applications 26-30	\$375
7. _____ applications 31-35	\$425
8. _____ applications 36-40	\$450
9. _____ applications 40+	\$575

Fee Due Date: Prior to first application approved

Review the attached fee schedule. Select the amount based on the predicted number of continuing education applications that you will use this year. Each date will count as an application. Any unused fees are NOT transferable to the next year.

Fees must be received prior to program approval. Make checks payable to, *Arizona Society for Respiratory Care*, and send to address below or via credit card at www.azsrc.org. P.O. Box 9342, Surprise, AZ 85374

**With Best Regards,
AzSRC Continuing Education Committee**

Mail:

Phone:

Email: