



HEALTH ETHICS TRUST

EXCELLENCE IN HEALTHCARE
COMPLIANCE SINCE 1995

VIA **zoom**

WEBINAR MEETING

TOPIC OF DISCUSSION

**Recent Guidance for
Compliance
Professionals: From CMS
to DOJ to OIG**



JULY 15TH | AT 1PM



LYNN BARRETT, ESQ., CHC, CCP

**WRIGHTWAY HEALTHCARE
PROFESSIONALS**

RECENT GUIDANCE FOR COMPLIANCE PROFESSIONALS:

Presented By: Lynn Barrett,
Wrightway Healthcare Professionals

THIS COURSE WILL BE A VIRTUAL PROGRAM



TUITION

Members: FREE Non-Members: \$99

HET MEMBERSHIP

1 Year Individual Membership w/Tuition Payment: \$200 (*\$199 savings*)
 1 Year Organizational Membership w/Tuition Payment: \$1,100 (*\$299 savings*)

Total \$ _____

FOUR WAYS TO REGISTER

1. **ONLINE** at www.HealthEthicsTrust.com in our store - safe, secure and encrypted.
2. **E-MAIL** your completed registration form to: cfreeman@corporateethics.com or mpastin@corporateethics.com
3. **FAX** your completed registration form to HET at: 571-551-6080.
4. **MAIL** your completed registration form to: **Health Ethics Trust 1727 King St., Ste 300, Alexandria, VA 22314**

CANCELLATION POLICY

Registration for Health Ethics Trust courses is an agreement to pay the applicable course tuition. Tuition for cancellations two weeks prior to program is refunded less an administrative fee to be determined. Tuition for cancellation after the deadline is not refundable, but a credit toward tuition for a future Trust program (tuition less the administrative fee; must be used within 12 months) will be issued in some cases. Those who cancel after the deadline must still pay the tuition that they agreed to pay by registering for the course even if they have not yet paid their tuition at the time of cancellation. Cancellation Policy is strictly enforced.

REGISTRATION INFORMATION

Name: _____

Title: _____

Organization: _____

Address: _____

City: _____ State: __ Zip: _____

Tel: (____) - ____ - _____ Fax: (____) - ____ - _____

E-mail: _____

Signature: _____

PAYMENT OPTIONS

Check

Credit Card Payment

Credit Card #: _____

Exp. Date: _____ CSC: _____

Cardholder Signature: _____

Name: _____

If Billing Address is different, please place here.

Address: _____

City: _____ State: __ Zip: _____