HFMD Annual Members' Meeting
April 19-20, 2024
Mermaid Event Center
2200 Mounds View Blvd
Mounds View, MN 55112

REGISTRATION FORM

EVENT DEADLINES:
Event w/Hotel Registration
APRIL 5, 2024

Event Only Registration
APRIL 14, 2024

ALL INFORMATION IS REQUIRED:

YOUR NAME:____

FULL ADDRESS: ____

EMAIL: ______________________________ PHONE: ____________________

Please list all immediate family members attending. Use more than one form if necessary. If children are attending the HFMD provided Child Programming, please provide their ages below and fill out a Child Program Registration Form.

REGISTRATION FEE *(check one)*
Enclosed is the event registration fee.

_____ $20/person

_____ $40/family

_____ Please waive the registration fee

NAME	AGE	CHILD CARE	CHECK ALL THAT APPLY	LIST BLEEDING DISORDER TYPE	List HTC
		❑ NO ❑ YES	❑ Bleeding Disorder ❑ Spouse ❑ Parent ❑ Sibling		
		❑ NO ❑ YES	❑ Bleeding Disorder ❑ Spouse ❑ Parent ❑ Sibling		
		❑ NO ❑ YES	❑ Bleeding Disorder ❑ Spouse ❑ Parent ❑ Sibling		
		❑ NO ❑ YES	❑ Bleeding Disorder ❑ Spouse ❑ Parent ❑ Sibling		
		❑ NO ❑ YES	❑ Bleeding Disorder ❑ Spouse ❑ Parent ❑ Sibling		
		❑ NO ❑ YES	❑ Bleeding Disorder ❑ Spouse ❑ Parent ❑ Sibling		

How many adults and children will be attending each meal?

Friday Dinner: _____ Adults _____ Children
Saturday Breakfast: _____ Adults _____ Children
Saturday Lunch: _____ Adults _____ Children

PLEASE NOTE!
THE HFMD WILL MAKE ALL ROOM RESERVATIONS!
This is on a first come, first serve basis.
Remit this registration form to: info@hfmd.org

____ **NO HOTEL NEEDED**

____ I will cover the cost of my hotel room of $162.15 per night. ____ A check is included. ____ Charge my card listed on this form

____ I would like HFMD to cover the cost of my standard room for Friday, April 19th, 2024.

____ We are traveling more than 150 miles one way; I would like HFMD to cover the cost of my standard room for Fri. & Sat.

____ I request mileage reimbursement *(available for those living over 150 miles away from the event)* Maximum reimbursement $75.

Mail this form and any payments to: HFMD ▪ 750 South Plaza Drive ▪ Suite 207 ▪ Mendota Heights, MN 55120 ▪ 651-406-8655

Card Number: ______________________________ Expiration Date: _____ / _____ Security Code: _________

Name on Card:______________________________________ Zip: ___________ Amount: $___________