



SPECIALTY HEALTH EDUCATION, INC.

P.O. Box 992 • Blue Bell, Pennsylvania 19422

Dear Nurse Educator/Department Manager:

We would like to thank you for your interest in our *Online Sedation Clinical Competency Program*. In order to secure your *Online Sedation Clinical Competency Program* hospital subscription rate, please complete the following documents included with this download:

- *Specialty Health Education, Inc. Online Sedation Clinical Competency Program Hospital Subscription Rate Order Form*
- *Specialty Health Education, Inc. Credit Card Authorization Form*

Fax the completed forms to our office at 610-630-6676. Once processed, the hospital access code will be forwarded to your contact person via e-mail and U.S. Mail.

The *Online Sedation Clinical Competency Program* hospital subscription code is valid for a period of one (1) year from the date of issue. The subscription code may be activated by up to a maximum of 500 individual participants. Once activated, participants will have until the expiration date of the subscription to complete the program.

If you have any questions related to ordering your hospital subscription, please contact our office at 610-630-3990.

Sincerely,

Michael Kost, DNP, CRNA

President

Specialty Health Education, Inc.



HOSPITAL SUBSCRIPTION RATE ORDER FORM

ONLINE SEDATION CLINICAL COMPETENCY PROGRAM



Hospital Contact Person: _____

Hospital: _____

Department: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ - _____ E-mail address: _____

Once processed, the hospital access code will be forwarded to your contact person via e-mail and U.S. Mail.

Method of payment:

Credit Card Payment:

Forward the completed Credit Card Authorization Form (*page 3 of this PDF*) and this Order Form via fax to **(610) 630-6676**

-or-

Forward via U.S. Postal Service to:
Specialty Health Education, Inc.
P. O. Box 992
Blue Bell, PA 19422

Check Payment:

Note: If paying by check, your code will be issued after the check has cleared (approximately 10 business days).

Please forward this completed Order Form with your check payment for \$399.00 to:

Specialty Health Education, Inc.
P. O. Box 992
Blue Bell, PA 19422

How did you learn about *Specialty Health Education, Inc.'s Online Sedation Clinical Competency Program*?



CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize *Specialty Health Education Inc.* to charge my credit card account in the amount of: \$_____ for goods and/or services.

Visa  MasterCard 

Credit Card Number: _____

Expiration Date: ____ / ____ Security Code: _____ (from back of card)

Hospital Name (if using hospital card): _____

Credit Card Billing Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ - _____

Requested Shipping Address (If different from Billing Address):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ - _____

X _____

Cardholder's Signature

Date

Your completion of this authorization form helps us to protect you, from credit card fraud. *Specialty Health Education, Inc.* will keep all information entered on this form strictly confidential.

**Fax completed form to *Specialty Health Education, Inc.* at (610) 630-6676.
Your Order or Registration will be processed upon receipt of this completed form.**