Bring the RightSleep® Course to You

Name _____ Practice name: _____

Years in practice _____ Years treating sleep disorders _____

□ Office Address _____

□ Home City : _____ State: _____ Zip: _____

Phone: Cell: _____ Office : _____

Email: _____

Requested RightSleep® Course Date(s) : _____

Location: Private conference room in your practice building or near you that will be fully dedicated to the course. Rental charges, if they apply, to be covered by enrollees.

Registration:

Cost for the two day RightSleep® course is $5,000 for practice of 1-3 clinicains. The team members are free of charge. Payment in full is expected once a date has been selected. If the date must be changed for any reason the payment is not refundable but all attempts will be made to reschedule the course again within a month.

1-3 Clinicians	**$5,000.00**	_____
___ additional Clinicians @	**$1,200.00 ea**	_____
Dr. Gominak travel expenses		**$750.00**

Total: _____

Return Completed form to:
Stasha Gominak, MD, RightSleep®
1635 NE Fremont St
Portland, OR 97212
Or scan and email to
sgominak@yahoo.com

Payment Options:
Payment by check, or credit card
Checks payable to RightSleep®
Name on Card _____
Credit Card # _____
Exp. Date ____/____ CSV code _____
Signature: _____

Names of clinicians and number of team members for each: _____

_____

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