



2010 International Treatment Center's Cooperative Conference

Southworth
ASSOCIATES
Interventions, Consulting & Monitoring

February 1, 2010

Dear Treatment Center / Interventionist,

If you have attended before the following requirements are just a reminder. If this is your first time at the ITCC Conference and you have any questions please call Boris, he will be handling all lodging needs, at (772-633-1097) or me (208-323-9555).

- **Please do not make any travel arrangements until your reservations have been confirmed.**
- *Plan to attend the whole conference, which begins at 12 pm on Monday, April 26 and finishes at 9 pm on Wednesday, April 28. If you cannot attend the whole conference please let us know so we can refund your registration fee and free up your seat for someone else.*
- Out of courtesy for the presenters there will be **no** cell phone or pager use, no text messaging, and no instant messaging thru cell phones during the presentations. You will have frequent breaks to make calls and check voicemail.
- *Each facility will be given ten minutes to present the three things that they do best and what makes them unique. Each interventionist will be given five minutes to present the things that they do best and what makes them unique. All are welcome to bring handouts but do not bring visual presentations (no PowerPoint, videos, etc). We recommend bringing enough material for 90 people. Table space will be available for handout materials.*
- We ask that you speak only about the treatment center which paid your registration fee.
- All meals during the conference are provided with the exception of dinner on Tuesday evening. Tuesday after the presentations hors d'oeuvres will be provided. If you have any special dietary requirements please let Boris know as soon as possible.

Please fill out the workbook form and the registration form and return it, preferably via email, to Southworth Associates as soon as possible. This information will be used in the workbook you will receive at the conference. By having this information preprinted on the worksheets you will be able to spend more time presenting your unique features and answering questions. Please remember that the registration process is on a first come first served basis and spots cannot be guaranteed.

If you have any questions please check out our website at (www.southworthassociates.net/conferences.html) for the most current information. If you need to contact the office about the conference, please send us an email or leave us a voicemail at 800-386-1695 x160.

Thank you,

Christopher J. Stogdill
Southworth Associates
Southworth.Conferences@gmail.com

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The ITCC Conference is an opportunity to exchange information in an effort to create a seamless continuum of care to meet the needs of all patients. During the conference each facility or interventionist is provided a formal opportunity to present information about what distinguishes their services and programs. There are also numerous networking opportunities and a chance for a little relaxation in beautiful Vero Beach, Florida. Our hope is that with the information gathered at this conference everyone will know where to turn when they are presented with a situation that is outside of their area of expertise.

Who Should Attend: - Admissions Personnel - Medical Directors - Treatment and Discharge Planning Personnel

Fees	
Fee includes attendance to all sessions and meals. Fee is \$1000 per facility and includes two staff members. Interventionist fee is \$500 per person.	
Facility	\$1000
Interventionist	\$500
Total	\$

Name of Attendee: _____

Job Title: _____

Name of Attendee: _____

Job Title: _____

Contact Information:

Facility: _____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Please return Registration Form to:
 Southworth Associates
 5530 W. Emerald
 Boise, Idaho, 83706
 Phone: 208-323-9555 Fax: 208-323-9222
 Email: Southworth.Conferences@gmail.com

Method of Payment

- Credit Card
- Check

Name as it appears on Credit Card: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Card Number: _____

Expiration Date: _____ / _____ **Please circle type of card:**

Card ID Number: _____ Visa MasterCard Discover American Express

(Visa, MasterCard – last three digits on back of card; Discover – on back of card;

American Express – on front of card above the card number)

Payment Amount: _____

Authorized Signature: _____ **Date:** _____

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Facility/Company: _____

Location: _____

Admissions: _____ Website: _____

Patient Gender Male Female Both

In House Detox Yes No

Tobacco Free Campus & Staff Yes No

Accept Insurance Yes No

Patients Case Managed Yes No

Patients Monitored Yes No

Financial Aid Yes No

AIS or NAATP Membership AIS NAATP Both Neither

Treatment Information:

Client Age Range: _____ # of Beds _____ Years Open: _____

Type of treatment

Length of Stay

Cost

Presenters:

Name: _____ C: _____ email: _____

Title: _____ W: _____ F: _____ O: _____

Name: _____ C: _____ email: _____

Title: _____ W: _____ F: _____ O: _____

Unique Features:

1)

2)

3)

Notes: