EHAC Event Information - Hospital Participation Form

Contact Information

Hospital Name: ____

ACC Hospital Account Number: ____

ACC Reviewer: ____

Hospital Contact Name: ____

Phone: ____________________________________ Extension: _______________________

Email: ____

EHAC Event Information

Event Name: ____

Date: _________________________

Location: ______________________

What are you sharing? (Education, testing, demonstrations? Please explain): ___________________

____

Social Platform Information (If you are sharing your event information on your social channels, please let us know how to tag):

Facebook: ____

LinkedIn: ____

Instagram: ____

Other: ____

Please submit your information to jcash@acc.org. By submitting this form to ACCF, you are allowing us to share your EHAC event information.

If you have any questions, please contact Jenn Cash at jcash@acc.org.