



## LWML CNH RETREAT

August 27-29, 2021

Registration – Friday 4 pm; Checkout – Sunday 11:30 am  
**Episcopal Conference Center Oakhurst (ECCO)**  
 43803 Highway 41, Oakhurst, CA 93644

## REGISTRATION FORM

(Please print clearly and complete all items on both pages.)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

E-MAIL \_\_\_\_\_ ZONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CHURCH/CITY \_\_\_\_\_

### REGISTRATION FEES *Per Person* (Make a check mark to the left of the item; add up costs for your check amount.)

<input type="checkbox"/> Single Room by 7/8/21	\$275.00	\$ _____	(bed, 5 meals, linens)
<input type="checkbox"/> Single Room <b>AFTER 7/8/21</b>	\$300.00	\$ _____	(bed, 5 meals, linens)
<input type="checkbox"/> Double Room (2 beds) by 7/8/21	\$225.00	\$ _____	(bed, 5 meals, linens)
<input type="checkbox"/> Double Room (2 beds) <b>AFTER 7/8/21</b>	\$250.00	\$ _____	(bed, 5 meals, linens)
<input type="checkbox"/> 3-4 in Room (twin beds) by 7/8/21	\$175.00	\$ _____	(bed, 5 meals, linens)
<input type="checkbox"/> 3-4 in Room (twin beds) <b>AFTER 7/8/21</b>	\$200.00	\$ _____	(bed, 5 meals, linens)
<input type="checkbox"/> One Day Only (Saturday 8:30am check-in)	\$125.00	\$ _____	(3 meals)
<input type="checkbox"/> RV Hook-up	\$125.00	\$ _____	(5 meals)

**TOTAL REMITTANCE \$ \_\_\_\_\_**

**\*\* PER ECCO POLICIES**

**NO REGISTRATIONS OR REFUNDS AFTER August 20, 2021\*\***

Make checks payable to **LWML CNH** – your canceled check is your confirmation.

Mail Registration Form with check to: Vicki Ewart  
 P.O. Box 1855  
 Atascadero, CA 93423

Questions?

Call Vicki Ewart at 805-441-0860 or email at [ewarts@mac.com](mailto:ewarts@mac.com)  
 OR LaVada Terrell at 408-893-3367 or email at [lavada1451@outlook.com](mailto:lavada1451@outlook.com)

Registration continues on page 2.

NAME: \_\_\_\_\_

Check all that apply to you:

\_\_\_\_\_ First Time attending a LWML CNH Retreat?

\_\_\_\_\_ Vegetarian \_\_\_\_\_ Vegan \_\_\_\_\_ Gluten Free \_\_\_\_\_ Diabetic

\_\_\_\_\_ Food Allergies: \_\_\_\_\_

\_\_\_\_\_ I use a: \_\_\_\_\_ Walker \_\_\_\_\_ Cane \_\_\_\_\_ Wheelchair

\_\_\_\_\_ Nurse – I'm willing to serve as needed.

Age Group: \_\_\_\_\_ 18-35 \_\_\_\_\_ 36-50 \_\_\_\_\_ 51-70 \_\_\_\_\_ 71+

**Roommates:** *Write down your preferred roommate(s). Check with them and tell them to put the same name(s) on their forms; all rooms/beds will be filled as requested; we will try to accommodate your wishes; however, no guarantees; first come - first served*  
**REGISTER EARLY!!**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL/HEALTH INFORMATION

Insurance Name/Type: HMO/PPO/Medicare: \_\_\_\_\_

Policy# \_\_\_\_\_

Health Conditions (i.e. allergies, chronic conditions, special circumstances, medications) – need to know prior to emergency treatment.

\_\_\_\_\_  
\_\_\_\_\_

Physician Name/Phone# \_\_\_\_\_

\_\_\_\_\_

EMERGENCY CONTACT INFORMATION: Name/Phone #/Relationship

\_\_\_\_\_