IHCA/INCAL is currently seeking proposals for a Dietary Conference to be held on July 20 in Indianapolis. Presentations must be relevant to the management and operation of the dietary department within a LTC facility or Assisted Living facility, as well as, presentations that focus on person-centered dining services. Proposals must be submitted by April 30th.

Call for Presenters Form

1. Presenter Information

Presenter (Main Contact): _____
Title: _____
Company/Facility: _____
Address: _____
City, State, Zip: _____
Phone/Fax: _____
Email: _____
Additional Presenters: _____
Email: _____

2. Education

Please list **all** post-secondary education and degrees completed. *This information is essential for the continued education credit approval process.*

Institution: _____
Major: _____
Degree: _____
Year of Completion: _____

Institution: _____
Major: _____
Degree: _____
Year of Completion: _____

Institution: _____
Major: _____
Degree: _____
Year of Completion: _____

3. Bio

Please include a bio in 150 words or less that describes your professional background and experience. *(bio must be in paragraph style and longer than 5 sentences, a CV/resume is not acceptable).* If you already have a professional bio completed, please attach to this form. If this proposal is accepted, publications and introductions may include excerpts of this summary.

_____

4. Program Information

Program Title: _____

Note: Title may be changed by IHCA.

Program length: _____ 60 min _____ 1 hr 15 min _____ 90 min

My program applies to: (check all that apply)

Nursing Homes:	_____	Assisted Living:	_____	Home Health:	____
Adult Day Service:	_____	Adult Foster Care:	_____	Hospice:	____

My program is designed for: (check all that apply)

Administrators:	_____	Owners:	_____	HR Dept:	_____
Nurses:	_____	Dept. Directors:	_____		
Other: (specify)	_____				

My program can be delivered as: (check all that apply)

In-person Training:	_____	Webinar:	_____

Please attach learning objectives and a presentation summary in 150 words or less, explaining the information you will present. Note: If this proposal is accepted, publications may include excerpts of this summary.

5. Travel Expenses (if applicable)

_____ I plan to pay for my own travel expenses.
_____ I will need IHCA to pay for my travel expenses. (See note below)

Please give an estimate of expenses and explain what that would include.

_____
_____
_____

6. Submit Your Proposal

Please be sure both the description of your professional background, learning objectives and program description are attached. Please make sure all sections of the application form are completed prior to submission. Incomplete forms will NOT be considered in the selection process. Submit all forms to:

Indiana Health Care Association
Attn: Katie Niehoff
One North Capitol, Suite 100
Indianapolis, IN 46204

Or
kniehoff@ihca.org

Or
Fax (317) 638-3749