2025 ID/DD Symposium

Tuesday, June 24, 2025

Northfield Inn, Suites & Conference Center
3280 Northfield Drive
Springfield, IL

ABOUT THE EVENT
ID/DD SYMPOSIUM

Each year the Illinois Health Care Association (IHCA) and The Center for Developmental Disabilities Advocacy and Community Supports (The Center) present the ID/DD Symposium to bring providers updates on the hot-button issues currently affecting this special population.

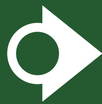
From the Division of DDD and HFS to training providers who cater to DD professionals, this symposium will give you the information you need.

CREATED FOR ID/DD PROVIDERS
SCHEDULE

I8:00 - 9:00 am	Registration
9:00 – 10:00 am	Session 1
10:00 – 10:15 am	Break
10:15 – 11:15 am	Session 2
11:15 – 11:30 am	Break
11:30 am – 12:30 pm	Session 3
12:30 – 1:30 pm	Lunch
1:30 – 2:30 pm	Session 4

Final Remarks/Dismissal

This year’s event will be a hybrid event.
We hope to see you there!



EARN CE CREDITS

Participants will earn up to 4 Continuing Education Credits for attending this event.

MULTIPLE DISCIPLINES

This activity meets the IDHS requirements for CEs for QIDPs. CE credits will also be given for nursing home administrators, licensed nurses and social workers.

VIRTUAL OPTION

This year’s symposium will be streamed live virtually. Registants will be required to register for either the in-person event or the virtual option.

For more information visit the link **WWW.IHCA.COM/SEMINARS**

ID/DD Symposium| June 24, 2025 | In-Person

Participant Name	Email Address

*** NOTE: A unique email address is required for each attendee for CE Certificate purposes.**

Contact Person: ____

Facility: ____

Address: ____

City: ____ State: __________ Zip: __________________

Phone: ____ Fax: __________________________________

❑ CDDACS Member ❑ IHCA Member ❑ LTCNA Member

Payment:

____Registration—IHCA/The Center/LTCNA Member..**$150 per person**

____Registration—Non-member...**$200 per person**

Total Registration Fee____________

****A $25 per person late fee is required for <u>In-Person registration</u> submitted less than three (3) business days prior to the event. Substitutions will be accepted on-site for registrants unable to attend.**

Total Late Fee ______________________

TOTAL __________________________

Payment:

□ Check enclosed **OR** Charge to: □ Visa □ MasterCard □ American Express □ Discover

\# ____ Expiration Date: ________________________

Security Code: _________ (3 digits REQUIRED)

Credit Card Billing Address:____

Credit Card Billing Zip Code:__________________ Signature: ____

Return with payment to:
Illinois Health Care Association
1029 S. Fourth Street
Springfield, IL 62703

OR

Fax: 217.528.0452
Register Online

AMOUNT	CK#/ CC	MEMBER STATUS	DATE

FOR IHCA USE ONLY

ID/DD Symposium | June 24, 2025 | Virtual

Participant Name	Email Address

*** NOTE: A unique email address is required for each attendee for CE Certificate purposes.**

Contact Person: ____

Facility: ____

Address: ____

City: ____ State: __________ Zip: __________________

Phone: ____ Fax: _________________________________

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