National Teaching Institute & Critical Care Exposition®
Indianapolis | May 2-5

# SUNRISE SESSION 2027 NTI INDIANAPOLIS APPLICATION

To complete this application, click in each section and fill in the information below.
**Please complete the entire application, save, then email to sunrise@aacn.org.**
Sunrise Sessions at NTI Indianapolis will be offered **May 4-5, 2027**.

**APPLICATION DEADLINE - February 5, 2027**

**Session Preferred Day (check one)**

**Tue. May 4 Sunrise Session 7:00-8:30am** ❑
**Wed. May 5 Sunrise Session 7:00-8:30am** ❑

**Sunrise Sponsor Fees:**
$29,000 on or before Feb 5. $31,000 Feb 6th and later. Breakfast fees are $55.00 per person, per agreed-upon capacity.

**Number of attendees the sponsor is committing to** ____

**Would you like to have this Sunrise Session shown during NTI Virtual, June 7-9, 2027?**

**Yes** ❑
**No** ❑

If yes, would you like AACN to record the In-person Sunrise session for $1000 ❑ **OR** record the Sunrise session yourself before the In-person event at your own expense ❑

**Corporate Sponsor**

**Sponsor's Business Address** | **City** | **State** | **Zip**

**Contact Name** | **E-mail** | **Phone**

**Title of Session (max 100 characters with spaces):**

**Session Description (max 500 characters with spaces):**

**Learning Objectives – 1 or 2 (max 140 characters with spaces, each Outcome):**
"At the end of the session, the attendee will be able to…"

- 
- 

National Teaching Institute & Critical Care Exposition®
Indianapolis | May 2-5

| | | |
|---|---|---|
| **Primary Facilitator's Information:** | | |
| Name: | Credentials: | |
| Job Title: | | |
| Institution: | | |
| Mailing Address: | | |
| City: | State: | Zip: |
| Phone: | E-mail: | |
| **Secondary Facilitator's Information:** | | |
| Name: | Credentials: | |
| Job Title: | | |
| Institution: | | |
| Mailing Address: | | |
| City: | State: | Zip: |
| Phone: | E-mail: | |
| **Additional Facilitator's Information:** | | |
| Name: | Credentials: | |
| Job Title: | | |
| Institution: | | |
| Mailing Address: | | |
| City: | State: | Zip: |
| Phone: | E-mail: | |

**Patient Population (select the one that best fits this session)** ❑ Pediatric ❑ Adult ❑ Not Applicable

**Area of Practice (select the one that best fits this session)**

❑ Progressive Care ❑ Critical Care ❑ Long Term Acute Care ❑ Acute Care ❑ Telehealth ❑ PACU ❑ ED