



## COURSE REGISTRATION FORM

(Please Print)

Name(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor and Clinic Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province/State \_\_\_\_\_

Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

Website \_\_\_\_\_

Course Name \_\_\_\_\_

Course Date \_\_\_\_\_ Location \_\_\_\_\_

Total Course Fee \_\_\_\_\_

Payment Method:  Visa  MasterCard  Check

Card Number \_\_\_\_\_

Expiry Date \_\_\_\_\_

Cardholder Name \_\_\_\_\_

Credit Card Billing Address \_\_\_\_\_

Card Holder Signature \_\_\_\_\_

How did you hear about this course? \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please fax completed form to: (888) 891-6485