



Course Registration
(PLEASE PRINT)

Today's Date _____
Company Name _____
Address _____
City _____ State _____ Zip _____
Contact person _____
Phone _____ Fax _____
E-mail _____

Course Desired (circle all that are appropriate)

First Aid:	Pediatric	Standard	
CPR:	Professional	Adult/Pediatric	Adult
Other Programs:	AED	Bloodborne pathogens	Oxygen

Specify _____

Location of Training _____
Date of Training _____
Start Time _____ Length of class _____
Total price per student \$ _____

Please complete the information below and return the white copy, retain the yellow copy for your records.

Students Name(s): _____
Number of students* _____
Total Amount Due \$ _____ (Price per student multiplied by number of students)
Print name: _____ Signature _____

*This is the minimum that you will be charged. Additional students may be added to the class and will be billed. Observers are not permitted in the class.

Cancellation of class requires 3 business days or may be subject to a rescheduling fee of 20%.

Payment method: **CASH** **CHECK** Purchase order # _____
 VISA **AMEX** **MASTERCARD**

Cardholders name: _____
Card Number: _____ **Expiration** _____
Signature of Cardholder: _____

Office Use Only

Date Sent: _____ by: _____
Date Returned: _____ by: _____
Total Amount Received: _____ Confirmed: _____