

Registration Form

Name: _____ **SS#:** _____

Address: _____

City/State/ZIP: _____

Phone: _____

Method of payment (cash, check, VISA, MasterCard): _____

Name on card: _____ **Account #:** _____

Expiration date on card: _____

Course Title: _____

Total Fees: _____ **Total Fees Paid:** _____

Accommodations requested to fully participate: _____

Registration is not complete until all fees are received. Payment secures space in a class.

Do you have any course or program suggestions to help Continuing Education serve you better?

The U.S. Department of Health and Human Services requests that we submit the following information.

Birth Year: _____

Please choose one: (Oriental, Black, American Caucasian, Indian, Foreign Citizen, Spanish Surnamed American)