REGISTRATION FORM

Name _____
PRINT CLEARLY

I am a ☐ PT ☐ PTA ☐ ATC ☐ MD ☐ DC ☐ OT ☐ Other _____

Employer _____

Mailing Address
for Confirmation Letter _____

City _____ State _____ Zip _____

Telephone _____

Fax _____

Course Title _____

Location _____

Have you taken a course from us in the past? yes ☐ no ☐

E-Mail _____

☐ I do not wish to receive any additional information from Advances in Clinical Education via e-mail

CANCELLATION POLICY

Registration fee less a $50.00 administration fee can be transferred or refunded with 2 weeks written notice; notice received after that time is subject to only a 50% transfer or refund less the deposit. If cancellation is received less than 72 hours before the start of

METHOD OF PAYMENT

☐ Check Or Money Order Enclosed

☐ Charge My Credit Card ☐ VISA ☐ MASTERCARD

Card Number _____ Exp. _____

Amount to Charge: _____ CVV Code: _____

Signature _____

Address _____

City _____ State _____ Zip _____

Make Checks Payable To:
ADVANCES IN CLINICAL EDUCATION
10020 SW Grabhorn Rd. Aloha, OR 97007
TEL. 1-503-642-4432 FAX 1-503-848-6384