[Course Registration Form]

Taylor McAdam Bell Neuroscience Institute

Washington Hospital Healthcare System

Demographics

This is how your name will appear on your name badge. *required

First Name: _____

Last Name: _____ Suffix (Jr., Sr., etc.): _____

Company/Institutional Affiliation: _____

Specialty: _____

Degree: ☐ MD ☐ DO ☐ PhD ☐ RN *required

☐ Other, please indicate: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Telephone ( ) _____ Fax ( ) _____

Email Address: _____

How did you hear about this course?

☐ Direct Mail ☐ Email ☐ Place of Employment ☐ Word of Mouth

Special Dietary Requirements: _____

Registration Fees

Physics Course Fee

$3,500

Total Due: _____

Payment must accompany registration.

Requested 2019 Course Date*

Physics Course: ☐ 4/22 - 4/24/19 ☐ 10/14 - 10/16/19

*minimum attendance required

Method of Payment

The following methods of payment are acceptable for the registration fee:

1. Checks: Make payable to Washington Hospital Healthcare System
2. Credit Card Payments (We encourage all credit card users to register by phone)

   ☐ Visa ☐ Master Card ☐ American Express ☐ Discover

   Credit Card No.: _____

   CVD No.: _____ (3-digit number on the back of your credit card)

   Expiration Date _____ (month/year)

   Signature _____

Fax completed form to (510) 608-1387

[2000 Mowry Ave., Fremont, CA 94538 • (510) 818-6103]