

## REGISTRATION FORM

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**Contact Information:**

Name: \_\_\_\_\_

Institution/Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

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

Postal Code/ZIP: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Email: \_\_\_\_\_

Special Needs: \_\_\_\_\_

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**Registration**

Course Fee: \$90 Canadian per person\*

Providence Health Care Staff: Free

\*Should you be unable to attend this seminar, a \$45 refund is offered

**Payment information:**

Check is enclosed (*payable to Providence Health Care*)

Credit Card (*select one*)

Visa                       Master Card                       American Express

Name of Cardholder (*as it appears on the card - please print*)

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Signature (*required*): \_\_\_\_\_

Card #: \_\_\_\_\_

Expiry date (*month/year*): \_\_\_\_\_

**Please fill out the registration form and fax to (604) 806-9071**

For more information, please call June at (604) 806-9952 or email:  
jmonthatawil@providencehealth.bc.ca (additional forms available on  
request from the same email address)