

Course Date:	6/28/2012 - 6/29/2012	Course #	39290-P	STUDENT PROVIDER
---------------------	-----------------------	-----------------	---------	-------------------------

LEGIBILITY CRUCIAL — please use Adobe Acrobat to fill out/print or if by hand, print clearly...

Name: _____ (How your name will appear on the certificate)

Address (Home/Business): _____

City, State, Zip: _____

Business Phone: _____ Home Phone: _____

Cell Phone: _____ Fax: _____


Specialty: _____

Attending	Resident	AEMT-P
NP/PA	RN	

E-Mail: _____

Provider	Tuition	Credit Card Info.:	Visa	MasterCard	Discover
Physician:	\$850.00 (US)	Card Number:			
NP/PA:	\$550.00 (US)	Expiration Date:			
Auditor (Paramedic/RN):	\$225.00 (US)	Security Code:			
<div style="border: 1px solid black; padding: 5px; text-align: center;"> Make all checks payable to: "FSA 2353" </div>		Amount:			
		Signature:			

Please call 315-464-4773 before you mail your check and registration form to make sure the date you want is still available. Classes fill about 2-3 months prior to the date of the class and are filled on a first Pay first served basis

Mail this form & payment to: 	University Hospital c/o Michelle Lewis Trauma Services, Room 8601UH 750 East Adams Street Syracuse, NY 13210	Or Fax to: 315-464-6266 (payment must be included – send registration form, please fill out credit card info. and include with your fax)
--	--	---

REFUND/CANCELLATION POLICY

4 weeks prior to course	= Full Refund
2 weeks prior to course	= 50% Refund
Less than 2 weeks	= NO REFUND

OFFICE USE ONLY

ATLS#:	_____
Payment Received:	_____
Material Sent:	_____