

Course Date:	3/9/2012	Course # 39278-I	INSTRUCTOR
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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: _____

E-Mail: _____

Attending	Resident	AEMT-P
NP/PA	RN	

Provider	Tuition
Physician (Non-SUNY UMU/UH)	\$797.00 (US)
SUNY UMU/UH Resident/Physician	Call 464-4773

Make all checks payable to:
"FSA 2353"

Credit Card Info.:	Visa	MasterCard	Discover
Card Number:			
Expiration Date:			
Security Code:			
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:	_____