

<b>Course Date:</b>	9/6/2012 - 9/7/2012	<b>Course #</b>	39321-P	<b>STUDENT PROVIDER</b>
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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: \_\_\_\_\_

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;"> <b>Make all checks payable to:</b>  <b>"FSA 2353"</b> </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**

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

4 weeks prior to course	= Full Refund
2 weeks prior to course	= 50% Refund
Less than 2 weeks	= <b>NO REFUND</b>

**OFFICE USE ONLY**

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